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ABSTRACT

This project explored the feasibility for vocational rehabilitation of a perplexing group of patients awaiting separation from a state mental hospital. The patients were of dubious employability. The design was a series of sequential stages through which the 98 workshop participants passed, with attrition taking place at each stage. The program lasted for eight weeks and provided work adjustment rather than specific skill training. It consisted of a highly individualized, focused rehabilitation plan for each client, which centered around work assignments in the shop, but included counseling on a regular basis. Future plans were arranged for each client. A total of two follow-up studies were done. Results include: (1) graduation from the workshop greatly increased a client's probability of vocational rehabilitation; and (2) many patients, while adjusting to the workshop and later employment, experienced major difficulties in other spheres of community adjustment. (KJ)

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A Study of the Feasibility for Vocational Rehabilitation of a Perplexing Group of Mental Hospital Patients.

by

Albert Cohen
David Orzech

FINAL REPORT
May 1970

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Significant Findings for Rehabilitation Workers

1. One-third of all clients referred to the project--hence, by definition, presumed not feasible for vocational rehabilitation--were rehabilitated or moving towards this goal at the six-month follow-up.

2. Graduation from the workshop greatly increased a client's probability of vocational rehabilitation. Whereas almost half of the graduates were rehabilitated or moving towards this goal at the six-month follow-up, less than one-fifth of non-graduates held this positive DVR status.

3. Performance in the workshop also was positively related to subsequent vocational adjustment. Over 60% of graduates receiving positive work evaluations were rehabilitated or moving towards this goal; by contrast, less than 30% of graduates receiving negative work evaluations held this DVR status at the six-month follow-up.

4. With few exceptions, demographic and social-vocational background variables failed to differentiate workshop graduates from non-graduates. Differences were noted in greater assumption of family responsibilities by graduates, a more continuous pattern of past employment and fewer indications of heterosexual contacts.

5. Psychiatric diagnosis was related to rehabilitation success, in the direction of favoring non-psychotic patients. Within the psychotic category chronic undifferentiated schizophrenics tended to show least favorable success rates. Further, successful clients showed more acute onsets of symptomatology.

6. With one exception, none of the psychological tests used in this project predicted vocational performance of clients in the workshop or at follow-up. This was true both of well known instruments, such as the Wechsler Adult Intelligence Scale and the Purdue Pegboard, and more experimental tests.

7. The Counseling Scale of the Chicago Scale of Employability for Handicapped Persons was singular in correlating both with workshop evaluation and vocational adjustment six months later. The Scale, which was developed by Chicago JVS, is a paper-and-pencil rating instrument, which the counselor completes on the client following an office interview.

8. Staff impressions of clients, based on brief clinical intake interviews at the hospital, also proved non-predictive of vocational performance.

9. Many patients, while accommodating successfully to the demands of the workshop and subsequent employment, experienced major difficulties in social-recreational spheres of adjustment. Holidays and weekends were particularly lonely times, since most clients were isolated from families or friends.

10. The integration of psychiatric patients into an ongoing sheltered workshop serving a mixed clientele proved highly successful. Significant disruptions were rare and an atmosphere prevailed which discouraged acting out of sick roles and which promoted reality-oriented, work-appropriate behavior.

TABLE OF CONTENTS

		Page
FOREWORD AND ACKNOWLEDGMENTS		II
ABSTRACT		III
CHAPTER		
I	INTRODUCTION	1
II	METHOD	7
III	RESULTS	19
IV	DISCUSSION	37
V	SUMMARY & CONCLUSIONS	43
BIBLIOGRAPHY		46
APPENDIX - FORMS		48

FOREWORD AND ACKNOWLEDGMENTS

In the past few years, the field of vocational rehabilitation has become increasingly conscious and uneasy about post-psychiatric patients who are categorized in some fashion as doubtful prospects for rehabilitation. A few workshop programs, psychiatric hospitals, and state vocational rehabilitation administrators even have had the temerity to consider scrutinizing this population.

The research project herein reported attempts to lay some tracks in this wilderness of potential rehabilitants, and hopefully make a start at answering such questions as: who are the doubtful candidates; can we predict their likelihood of rehabilitation, and how can workshop programs help them; and how worthy are they of financial sponsorship by state departments of vocational rehabilitation.

The project received partial support from grants from the Office of Vocational Rehabilitation of the U. S. Department of Health, Education, and Welfare, under Project Number RD-505.

This was truly a cooperative project in concept and execution, and required at every stage the joint participation of Northville State Hospital, Northville, Michigan, The Michigan State Division of Vocational Rehabilitation, and the grantee agency, the Jewish Vocational Service and Community Workshop of Detroit.

We wish to express our appreciation of staff personnel who were actively involved in the project, namely, for Northville State Hospital: Mrs. Ella Elfer, psychiatric social work supervisor; David Ethridge, occupational therapist and rehabilitation counselor; Chester T. Horodko, M.D., rehabilitation coordinator; and Jacob J. Miller, M.D., clinical director.

For the Michigan Division of Vocational Rehabilitation: Harold T. Hayes, district supervisor; Raymond W. Hinz, supervisor, vocational rehabilitation unit; and Loren A. Reese, state supervisor of research.

Members of the Jewish Vocational Service and Community Workshop staff who were closely connected to the project included Albert Cohen, research director; Donald Galvin, counselor-psychologist; Eugene Greenspan, assistant director of JVS-CW; and Robert Horvath, counselor-psychologist.

Dr. Lloyd Meadow was research supervisor of the project until June, 1962. Dr. David Orzech succeeded Dr. Meadow in this capacity and completed the project. Dr. Henry J. Meyer, professor of sociology and social work at the University of Michigan, was research consultant during the entire course of the project.

Albert Cohen, Research Director

ABSTRACT

The purpose of this project was to explore the feasibility for vocational rehabilitation of a group of psychiatric hospital patients of dubious employability, who did not qualify for regular services by Michigan DVR. A second goal was to determine the ability of various selection procedures to predict successful rehabilitation outcome of these clients.

Following initial selection and testing, patients entered an eight-week intensive workshop program, which combined work adjustment training and counseling. Subsequent job placement and referral services were provided, and six and twelve months follow-ups were done. Of 146 patients referred to the project, 111 were accepted for service. Of these, a total of 76 completed the workshop. Although no strict control group was utilized, follow-up information was obtained on all (146) referred patients, thus permitting comparison among various groupings.

Results indicate that one-third of all referred patients were rehabilitated or actively moving towards this goal. Both graduation from the workshop and performance within it were positively related to subsequent vocational adjustment. Non-psychotic patients fared better than psychotics and chronic undifferentiated schizophrenics tended to do worse than other psychotics. Of all the psychological tests used, only the Chicago Scale of Employability for Handicapped Persons proved predictive of future vocational performance. Clinical staff impressions based on intake interviews were non-predictive.

CHAPTER I

INTRODUCTION

A. Background

With the advent of the ataractic drugs has come a revolution in the mental health field. Individuals who formerly would have been expected to remain hospitalized for long periods are now able to function relatively early in the outside world, and some others who previously would have required hospitalization are now able with medication to maintain themselves without it. Philosophically too the helping professions have swung gradually toward the view that, wherever possible, inclusion in society rather than exclusion from it represents the mental patient's most hopeful course. Consequently, significant concrete changes have resulted, including a sharp, marked increase in the number and type of individuals discharged from mental institutions and in the number of individuals living in the community who require varied professional aid to maintain themselves there.

As a consequence, community resources are severely strained. The traditional sources of help for the newly discharged individual are woefully insufficient to handle the greatly increased numbers. Further, the types of services previously offered no longer meet the new needs the clientele has.

Vocational rehabilitation agencies have recently entered the area of attempting to provide some of the necessary services. Problems have been multiple for many reasons - because of the relative lack of experience with this group of clients, because of the uncertainty around just what the needs are, etc. The determination of eligibility for service, for example, has been much more problematic and speculative with the psychiatric patient than with the more traditional physically disabled client. With the expanding emphasis on community responsibility and earlier rehabilitation for the psychiatrically ill, one of the major tasks for the field of vocational rehabilitation is to broaden its skills and adapt them to the discharged psychiatric patient.

B. Purpose

The overall purpose of this project was to study the feasibility for vocational rehabilitation of a perplexing group of patients awaiting separation from a state mental hospital.

Subsumed under this general purpose were the following major goals:

1. To evaluate and compare the accuracy of prediction of a variety of selection procedures and indices for identifying those patients who are potentially capable of benefiting from intensive vocational rehabilitative efforts.

2. To delineate critical characteristics of this population which differentiate between successful and unsuccessful rehabilitative outcomes.

Secondary goals of the study were:

3. To conceptualize and describe the factors inherent in the particular rehabilitation program studied (a workshop) which appear to affect the experiences and final evaluations of patients.

4. To describe administrative and organizational machinery required to provide services for this group of clients.

Finally, the project incorporated service functions for those patients selected for the program. The services included diagnostic evaluation, rehabilitative training, vocational counseling and job placement.

C. Review of Related Studies

Over the past ten years a body of literature has begun to accumulate which deals with the vocational rehabilitation of psychiatric patients. One of the earliest studies utilizing a workshop is that by Gellman (7*) which dealt with a group of non-hospitalized emotionally disturbed clients. The 59 clients in the group represented a variety of different diagnostic entities ranging from mental retardation to neurosis and psychosis. Following an eight-week workshop program, Gellman reported 46% "success" (defined as one year's continuous employment in the labor market) and only 24% without any benefit.

In a five-year study using a workshop within a Veterans' Administration hospital setting Hubbs (10*) employed matched groups of 48 workshop and 48 control patients. He found that a significantly larger number of patients from the workshop was able to leave the hospital. The author concludes further that a workshop within a hospital could provide long-range employment for those discharged patients who have serious problems in obtaining outside work.

The Vocational Adjustment Center of the Cincinnati Jewish Vocational Service reported results of a rehabilitation project with psychiatric

* Number refers to citation listed in bibliography of this report.

clients (4). Using a model similar to this project's consecutive stages, they divided the program into diagnostic, adjustment and placement phases. They found that of 324 clients referred to the initial phase (diagnostic), 148 remained by the time placement was started. However, only 32% of the original group were diagnosed schizophrenics, and there is no indication of how many of these remained in the program through placement. The report indicates that motivational factors appeared crucial in successful work adjustment, overriding skill and intellectual variables. Further implications to the study were 1) the necessity for incorporating placement responsibilities within the agency structure (only two clients were placed by the State Employment Service, the balance by JVS), and 2) the importance of the home in maintaining a client out of the hospital. (This point is also heavily emphasized by Freeman and Simmons (6) in a sociological study of the ex-mental patient, a study which has important implications for vocational rehabilitation.)

In a study which addressed itself to questions similar to our own, Jewish Vocational Service of Essex County, New Jersey (5) investigated the contribution of a workshop in the vocational adjustment of the adult schizophrenic patient. Utilizing a control group design and fairly stringent selective criteria (of 218 who were screened and evaluated, only 38 patients met the research qualifications), the study failed to reveal a statistically significant difference in the success rates of the group served in the workshop and those served without a workshop. However, both of these groups received rehabilitation services and were significantly more successful in vocational adjustment than the clients who were rejected for service. In a finding similar to the previously reported study by Cincinnati JVS, the authors note a greater success rate in placing clients than the State Employment Service. They conclude that since the factors which make for rehabilitation success are still largely unknown, a variety of services, both within and without the workshop setting, should be available to clients for maximal help.

Grace (8), in a study using 60 male schizophrenics in a VA hospital, reports one of the few significant positive findings of potential test indicators of rehabilitation success. In a post-dictive design, the subjects, all of whom had been in a hospital rehabilitation program for one year, were divided by raters into Progress and non-Progress groups. Clients rated "Progressive" scored higher on tests of abstract functioning (Proverbs) but not on Vocabulary. However, since no relationship between progress in this program and outside vocational adjustment was established, these findings are at best only suggestive.

A review of the literature indicates the great diversity in basic assumptions, methods and findings of the various studies. Few "hard"

data are cited and no definitive conclusions emerge. It is safe to say, however, that while this reflects accurately our current state of scientific knowhow, there does appear to be basic unanimity about the general direction of professional effort. Increasingly, attention is focused on the rehabilitation of the mentally disturbed patient on extra-therapeutic, non-traditional ways to complement and augment psychiatric treatment methods.

D. The Setting

In its initial phase the study involved the cooperative efforts of the Jewish Vocational Service and Community Workshop of Detroit and the Division of Vocational Rehabilitation (DVR) Unit of the Northville State Hospital. In 1962 this was expanded to include a second state psychiatric hospital, the Lafayette Clinic in Detroit. This extension was undertaken to supplement the flow of patients from Northville State Hospital.

1. The Jewish Vocational Service and the Community Workshop

The Jewish Vocational Service and the Community Workshop (JVS-CW) are closely affiliated agencies sponsored by the Jewish Welfare Federation of Detroit. The two function under one executive director and are located in proximity to each other.

The Jewish Vocational Service, an approved agency of the National Vocational Guidance Association, provides intensive vocational counseling and job placement services. The agency maintains a highly professional staff with limited case loads. It has a normal complement of seven professional staff persons plus its own clinical psychology department. The Jewish Vocational Service has for many years given focal attention to specialized services for hard-to-place persons with emotional difficulties, including persons with physical handicaps whose primary disabilities are emotional.

The Community Workshop provides adjunctive services to the Jewish Vocational Service in : a) determining the employability and placeability (diagnostic function), and b) developing the indicated potentialities to the highest possible functioning level (rehabilitative function) of exceptionally hard-to-place and complicated cases. Whereas the Jewish Vocational Service serves approximately 500 hard-to-place and career counseling cases a year (among other types of cases), the Community Workshop's adjunctive services are extended only to approximately 120 cases per year.

The Community Workshop may be described as a work adjustment "laboratory", providing a guided, graduated, and yet protected work

experience under conditions simulating normal employment as closely as possible. A variety of real work procured on a subcontract basis is performed; wages are paid, with increases as vocational adjustment improves, and attention is paid to attendance and punctuality.

Although production is given a desirable level of attention, primary focus of the workshop is on work adjustment training through the development of positive work patterns, work habits, relations with fellow workers, and relations with supervisors. Many of its clients have had little or no exposure to real work conditions and relationships and have substantial fears or anxieties, expressed directly or indirectly, regarding their work capacities. Those with physical or mental handicaps frequently have inappropriate attitudes about the disabilities incurred by their handicap.

The Workshop has a complement of four professional workers. The staff members are vocational counselors with clinical psychological training and experience appropriate to aiding the hard-to-place, vocationally maladjusted, and emotionally insecure. A Jewish Vocational Service counselor maintains contact with each case referred to the Workshop throughout the stay in the Workshop. Close consultation and liaison is maintained between the staffs of the Jewish Vocational Service and the Workshop regarding referral of the client to the Workshop, plans within the Workshop, subsequent progress, termination from workshop service, and vocational placement activities following conclusion of workshop service.

2. Northville State Hospital

Northville State Hospital is an institution built to serve the Detroit metropolitan area and is located 25 miles from downtown Detroit. The hospital population approximates 2100, of whom 800 to 900 are geriatric patients. The treatment program is predominantly focused on the long-term chronic patient. The theoretical basis of the treatment program is reality-oriented ego therapy, stressing function, ability, and health rather than psychopathological aspects.

The vocational rehabilitation program at Northville was initiated in the fall of 1956 by a counselor who went to the hospital one day per week. One year later the counselor was assigned to the hospital full time. A staff physician has been assigned part-time responsibility as medical rehabilitation coordinator, and a member of the social service staff provides liaison with DVR. This has served to bring the medical and adjunctive services into sharper focus in furthering rehabilitation goals.

Patients are referred to DVR by their ward physician, although

the proposal for such referral may originate with any staff member. Referral to DVR automatically activates the Social Service, if it is not currently active. The DVR counselor, after reviewing the referral and the case record, interviews the patient. Decision about eligibility for DVR service may be made then or it may be deferred. A joint evaluation and planning discussion is then arranged, including, as indicated, Social Service, Occupational Therapy, Work Therapy, Nursing and Psychology. The result is a jointly accepted program, with the vocational objectives integrated with all others.

3. Lafayette Clinic

The Lafayette Clinic is a research and training hospital located in Detroit and affiliated with Wayne State University's Medical School. It provides intensive psychiatric treatment for children and adults on both in-patient and out-patient basis as well as day care and night hospital facilities. The in-patient population is small (about 200) and largely composed of recent, acute admissions.

In addition to the traditional clinical services and a full complement of occupational and recreational therapy facilities, the clinic maintains an independent rehabilitation department whose function it is to plan and coordinate after-care programs for patients. After-care facilities include a drug clinic and a halfway house located in the community.

A full time counselor has been stationed at the Lafayette Clinic and serves as liaison between the Clinic and the Division of Vocational Rehabilitation.

CHAPTER II

METHOD

A. Overview

As a brief summary of its overall design, the project may be visualized as a series of successive stages (presented in Chart 1). Following the original selection of patients (Stage 1), the progress of patients through the various succeeding stages was largely governed by a process of self-selection. In other words, all patients, once they were selected for the study, were given the opportunity to complete the total series of stages. Attrition of patients, which occurred at various stages, was a result of the patient's inability to move ahead successfully in the program.

No control group per se was utilized in this study. The decision to forego a more conventional experimental control group design was based on two main considerations: 1) The well-known difficulties involved in establishing a true control group in a project including extensive service aspects and oriented around patients' differing needs for service; 2) our own conviction that at this stage of inquiry rigorous hypothesis testing was premature and potentially less fruitful than a more flexible search for meaningful insights into the rehabilitation process, out of which experimental hypotheses could then be devised.

B. Subjects

The subjects for the study were 146 hospital patients, 95 males and 51 females. They were selected to represent "perplexing" problems to the Michigan Division of Vocational Rehabilitation with respect to suitability for sponsorship for vocational rehabilitation services. Thus, these patients were considered unemployable at time of selection and had not worked in regular employment for varying periods of time, with some patients never having held regular, remunerative jobs. On the other hand, they were deemed to possess some degree of ultimate employability or work potential. In terms of a conceptualized continuum of acceptability for Michigan DVR services, this project thus addressed itself to the "gray zone": clients clearly feasible for regular services were excluded from consideration as "too good" and clients clearly unfeasible were rejected as "too poor" risks; the in-between, questionable group, which normally would have been excluded from consideration for service as ineligible, became the project's clientele.

In order to avoid preconceived notions as to what kind of patient would represent an appropriate referral, criteria of selection were

CHART 1

Referral of patient
by psychiatric staff (N=146)

Stage 1: Selection

a. Case record review
b. Prognostic Rating Scales #1 & #2
c. Staff presentation

(n=111)

Stage 2: Workshop Preparation

a. Psychological testing
b. Chicago Employability Scale, Counseling Section
c. Interviews

(n=98)

Stage 3: Workshop Program

a. On-the-job counseling
b. Staff conferences and consultation
c. Progress reports

(n=76)

Stage 4: Post-workshop Planning

a. Final testing and interviewing
b. Determination of employability
c. Individual and group counseling

leading to

job placement, or
DVR sponsored training program, or
return to the hospital

(n=76)

Workshop Dropouts (n=22)

Preworkshop Dropouts (n=13)

Rejects (n=35)

Stage 5: Follow-up after 6 and 12 months

a. Interviews
b. Hospital case record
c. Employment history
d. DVR status

held to a minumum. The original requirements called for patients aged 17 years and over without regard to lengths or number of hospitalizations, sex, race, creed or color. Diagnostic criteria broadly specified a primary diagnosis of psychosis or psychoneurosis but were later amended to include personality disorders as well. (In line with the experience of similar studies, we found a bewildering array of multiple and at times inconsistent diagnoses for many of our patients.)

Table 1 presents the breakdown of patients by hospital diagnosis at the time of their selection for the project. Inspection of the table reveals that approximately 80% of patients referred to the project carried a primary diagnosis of psychosis.

A final operational consideration for acceptance into the project was the patient's ability to use public transportation in unaccompanied commuting between hospital and workshop, a distance of 25 miles.

C. Procedures

1. Selection (Stage 1)

The selection process involved the following steps:

a. Initial referral was made by ward psychiatrists. They referred to the DVR office those patients who appeared ready for discharge planning. In the written referral by the physician specific attention could be directed to the JVS-CW Research Project or recommendations for service could be held more general.

Inevitably, this initial step in the referral process introduced a major factor of self-selection by patients. Those patients who requested from their ward physician referral to the project were more likely to be referred than patients who did not so request. Furthermore, patients who demonstrated a high level of motivation by repeated demands of this nature were more apt to obtain satisfaction than more passive individuals. Parenthetically, it may be noted that over its three-year life the project achieved an enviable, if not wholly deserved, reputation within the patient population as a major route of release from the hospital. This image in the hospital subculture came to our attention dramatically when, toward the end of the project, one patient was overheard to voice his concern to another patient about "getting out of here if the JVS Project stops."

b. All referrals to the Division of Vocational Rehabilitation were screened by that office for eligibility for the project. This initial review served to screen out those patients eligible for regular services under DVR sponsorship. Those case records referred on to the project

TABLE 1

Diagnoses[1], at Time of Selection for the Project, of Patients Who Were Referred to the Project and of Those Accepted for Service

Diagnosis	Referred to the Project	Selected for Service
Psychoneurotic Disorders	6	6
Psychotic Disorders	120	92
Paranoid Schizophrenia	(50)	(41)
Chronic Undifferentiated Schizophrenia	(50)	(40)
Other Psychoses[2]	(20)	(11)
Personality Disorders	16	13
Chronic Brain Disorders	4	0
All Diagnoses (Total)	146	111

[1]Based on Diagnostic and Statistical Manual - Mental Disorders, 1952, Amer. Psychiatr. Ass'n., Washington, D. C.

[2]This category included: Involutional reaction (1 patient), Depressive reaction (2), Simple schizophrenia (4), Hebephrenic schizophrenia (2), Catatonic schizophrenia (4), Acute undifferentiated schizophrenia (1), Schizo-affective (3), childhood schizophrenia (1), and Unspecified (2).

were abstracted by a staff member of the project and prepared for presentation to the selection committee. At this time, also, Prognostic Rating Scale #1 and a Research Data Sheet were completed on each project referral. (See Appendix) These referrals, numbering 146 in all, constitute the subjects of the project.

c. Final decision on whether a referred patient was accepted for service was made in a formal staff meeting by the Selection Committee. This committee consisted of the project supervisor, DVR counselor at the hospital, psychiatrist in charge of rehabilitation coordination, and representatives of social service, occupational therapy, and recreational therapy departments. Patient's ward physicians were invited to participate as were members of other interested departments. After a review of the case record the patient was interviewed briefly by the assembled staff to assess his current functioning and motivation for entering the program. Following the interview, members of the Selection Committee individually completed Prognostic Rating Scale #2 (see Appendix) and then arrived at a consensual decision regarding acceptance of the patient into the program.

During the three-year period of actual patient service the Selection Committee convened for a total of 70 meetings, or approximately once every two weeks. In these 70 meetings 146 patients were discussed for 229 separate times, i.e., many patients were brought up for discussion repeatedly to communicate progress in the program, re-evaluate a patient previously rejected, etc. Thus an average of three patients per committee meeting was discussed.

Of the 146 patients presented by DVR counselors to the Selection Committee, 111 were accepted for the JVS-CW program, and 35 were rejected. Among those rejected were mainly patients who, in the committee's opinion, were either 1) vocationally placeable through regular DVR services ("work potential too favorable") or 2) psychiatrically not ready to benefit from the project. This latter group included patients considered suicidal or homicidal risks. The 35 patients who were presented to the Selection Committee but not selected into the program will be referred to as the "rejects". While not receiving service by the project, this group was included in the follow-up activities (see below).

2. Workshop Preparation (Stage 2)

After the patient was selected for the project, a series of appointments was scheduled for him with the hospital DVR counselor and the project's rehabilitation counselor at JVS. These interviews were aimed at familiarizing the patient with some of the reality demands of the workshop situation, such as transportation, hours, wages,

and at providing reassurance and support. At this time, also, phychological testing was done, and the project counselor completed the Chicago Scale of Employability, Counseling Section (see Appendix).

This period between selection and actual start in the workshop lasted up to two weeks. For many patients the waiting period was anxiety-arousing and frustrating. Some regressed into highly disturbed behavior, including psychotic acting-out of an aggressive or sexual nature. Others indicated verbally their fearfulness to leave the relative security of the hospital and decided to withdraw from the program. In total, 13 of the 111 patients who were accepted for the program failed to start in the workshop for one of the above reasons. This group constituted the "Pre-workshop dropout group." Follow-up information was obtained on this group also, as on the "Rejects" and later dropouts.

3. The Workshop Program (Stage 3)

Following completion of their initial interviews and evaluation, patients entered the workshop for an eight-week period. Entry was spaced so that only one or at most two patients were admitted in any one week. Upon arrival at the shop each patient was introduced to the workshop staff, given a brief orientation and then assigned to a relatively simple job. He was also introduced to some of his co-workers to ease his social integration.

Since previous research in the workshop setting has indicated the desirability of mixing clients with diverse disabilities rather than treating them as separate groups, a deliberate attempt at integrating the research clients into the overall shop clientele was made. Thus, with the exception of a higher ratio of counselor-to-client in the research population, the program for these patients was identical with the ongoing workshop program.

As indicated earlier, work adjustment rather than specific skill training was the focus of the workshop program. Depending on the client, disturbances in work adjustment could be expressed in such varied areas as productivity (both quantity and quality), attendance and punctuality, interpersonal behavior (both with supervisors and co-workers), symptomatic control, and dress and personal cleanliness. In turn, many of these areas were clearly related to underlying difficulties in motivational and cognitive functioning.

Clients were closely observed at a variety of work situations. In order to evaluate each client's specific tolerances and proclivities, individuals could be tried on a large number of specific work conditions. For example, assignments were made to solitary, parallel and cooperatively performed tasks. "Masculine" type activity, involving strenuous

physical output, such as lifting and stock work, was contrasted with more sedentary jobs requiring possibly higher dexterity or finer motor coordination. Independent work and increased responsibility for directing other workers could be attempted for clients showing readiness for this, while others might remain in more highly controlled, supervised jobs.

Workshop counseling was done both informally and in regularly scheduled, weekly sessions. The informal contacts often involved acute, crisis-type interventions on the floor of the shop and approximated Redl's life space interview (13). The weekly sessions explored in greater depths some of the client's current behavior and attempted to help him to clarify underlying feelings around work, co-workers, supervisors, etc. In addition, toward the end of a client's workshop stay, vocational planning was undertaken to prepare him for termination and eventual employment or training.

An initial workshop conference was held on each client at the end of his first two weeks in the shop. These conferences were usually attended by the workshop staff, the client's counselor, the project supervisor and the DVR counselor from the referring agency (Northville State Hospital or Lafayette Clinic). They served to clarify initial impressions about the client's workshop adjustment and to formulate an individualized program of activities for the client. Throughout the eight weeks informal consultation among the staff occurred on an "as needed" basis. A final full staffing was held again at the end of the workshop training period, at which time plans for post-workshop services were decided on. At that point also further testing was done, and a global determination of employability was made. Two formal reports on each client were submitted to DVR, a progress report after four weeks of workshop attendance and a final evaluation at the end of the training period.

As was to be expected, many clients experienced considerable anxiety upon leaving the hospital. Pressures in the workshop situation, although controlled to some extent and considerably below those of the real world of work, proved difficult to manage for many of them. Close consultation between workshop staff and hospital psychiatric personnel was necessary to provide feedback on behavior disturbances, and to regulate medication dosage when necessary. Nevertheless, a number of patients were unable to tolerate the stresses to which the program exposed them and had to drop out of the project. In most cases patients who terminated a workshop program before the end of the eight-week period were returned to the hospital; in a few cases other arrangements were provided by family. Altogether 22 clients did not finish this phase of the program. These clients constitute the "Workshop dropouts." The 76 clients who successfully finished their eight-week stay at the workshop constitute the "Workshop graduates."

4. Postworkshop Planning (Stage 4)

As mentioned, toward the end of the workshop period determinations were made as to the client's current and eventual potential for employment. Based on such factors as overall workshop performance, psychiatric status and skill level, appropriate plans for each client were made by the workshop staff in consultation with the DVR counselor. If deemed immediately placeable, the client was provided with the regular placement services of JVS, including individual and group counseling around vocational objectives and job-getting techniques, referral to specific jobs and referral to other community resources such as the State Employment Service. In addition, coordinated planning was undertaken with the hospital to arrange for release to convalescent status and for help with out-of-hospital living arrangements. For patients who were not immediately placeable, plans were mapped out to provide those services which would increase their eventual success on the job market. This included, when necessary, provisions for vocational training, further extensions of the workshop experience, intensification of occupational training programs within the hospitals, and the like. Often brief training in specific skills, such as a course in typing, was recommended in order to increase a client's employability. Finally, for some clients, the staff recommendation was basically guarded insofar as it precluded return into competitive employment in the foreseeable future. Here recommendations were often for continued sheltered employment or for re-hospitalization. Even with these clients, it was expected that work programs within the hospital could be provided to consolidate and hopefully extend the gains made in the workshop program.

5. Follow-up (Stage 5)

Follow-up information was gathered on all 146 clients at two periods, first at six months following workshop completion (or its equivalent for those clients who did not achieve this phase of the program), and the second at twelve months following workshop completion. Information was obtained through a variety of sources, including interviews with the client whenever feasible, review of the hospital case record, and review of the DVR case record. Data were obtained concerning each client's hospital status at the time of the follow-up. For those clients who were still institutionalized, information concerning social adjustment and vocational performance in the hospital was obtained. For clients who were out of the hospital, data included information about living arrangements, vocational adjustment and DVR status (see Appendix for Follow-up Survey Form).

D. Tests and Instruments

Since one of the original goals of the study was to compare the accuracy of prediction of a variety of assessment procedures, a relatively large number of tests and rating scales was used. Among these were standard psychometric measures which need no introduction, as well as experimental instruments less widely used. In addition, several rating scales were designed specifically for the study. It should be noted that none of these instruments, whether well established or experimental, was used in determining the patient's eligibility for inclusion in the study or for deciding on his progress at any stage. Instead, they were designed to permit independent validation, through correlations with other behavioral criteria of patient outcome. The instruments will be discussed in the chronological order of usage in the project.

Stage 1 - Selection

At this point, Prognostic Rating Scales #1 and #2 were filled out.

Prognostic Rating Scale #1)

This scale was devised by the research staff of the Project. It consists of 17 discrete items, several of which are further divided into separate sub-categories. The items are based on a study of Zubin et al (14), who surveyed some 800 published articles relating to the prognosis of hospitalized schizophrenic patients. Despite major variations in methodologies and levels of sophistication among these articles, Zubin et al were able to cull out premorbid and diagnostic variables which appeared consistently and regularly to differentiate between positive and negative outcomes. They suggest that the direction of prognosis is relatively independent of the type of therapy administered in the hospital. For example, they found in 237 of the surveyed articles a positive prognosis when duration of illness prior to hospitalization was less than two years; in 19 articles a negative prognosis was reported with this variable and in one article an indefinite prognosis was mentioned. The 17 items included in our scale were each found in at least 15 studies surveyed by Zubin. While the scale consists of a 4 point continuum, in the analysis of the data points 1 and 2 were collapsed to indicate positive prognosis and points 3 and 4 to indicate negative prognosis. The scale was filled out by the project counselor prior to meeting the client; it was based entirely on the patient's hospital case record.

Prognostic Rating Scale #2

This scale, devised by the research staff, was designed to

formalize predictions by individual Selector Committee members concerning each patient's probable success in the Workshop and consequent vocational adjustment. These predictions were based on the material presented at the Selection Committee meetings and the patient's interview in the meeting.

Stage 2 - Workshop Preparation

At this stage much of the psychological testing was done. Specifically, the following tests were administered:

1. Wechsler Adult Intelligence Scale (WAIS)
2. Cohen Conceptual Thinking Test
3. Lafayette Clinic Reversed Digits Test
4. Purdue Pegboard
5. Self-Image Scale "What Kind of a Person Am I?"

In addition, the counselor completed at this time the Chicago Scale of Employability, Counseling Section.

Wechsler Adult Intelligence Scale (WAIS)

The WAIS was included to obtain a general measure of the client's intellectual functioning to aid in formulating vocational plans. In addition, clinical aspects of test performance, such as perseverance at tasks, reaction to failure, etc., were used in workshop planning.

Cohen Conceptual Thinking Test

This test was developed by Bertram D. Cohen, then of the Lafayette Clinic, and is designed to reveal cognitive dysfunctioning (in schizophrenic and brain-damaged individuals primarily). Its inclusion in the test battery was based on the assumption that workshop performance may be significantly related to the degree of conceptual disturbance. The test consists of two sets of eight cards each. The first eight cards (Series A) are placed in front of the subject in standard order: each card has a word printed on it - Auto, Whale, Ship, Shark, Dog, Bike, Lion, Canoe. The subject is told to sort these cards into two groups with four cards in each group. He is to arrange them so that the four cards in a group are alike in some way. Then he tells the examiner why he arranged them in the way that he did. It is possible to make arrangements so that six primary concepts emerge - animate-inanimate; land-water; color; card size; letter size; word position. The test is repeated using another series of eight cards designated series B. Scoring is based on the number of primary concepts and secondary concepts elicited. Three scores, for series A, series B, and combined A and B, are obtained.

Lafayette Clinic Reversed Digits Test

This is a second experimental test, developed at the Lafayette Clinic, and it is designed to test ability to mobilize energy effectively. In research studies conducted at the Lafayette Clinic the test correlated with biochemical indices of energy production in normal and schizophrenic subjects. It was included in this project because of the potential importance of this variable in workshop (and, later on, vocational) performance.

The test is a paper-and-pencil measure which requires the subject to reproduce digits 1 through 9 in reverse fashion. Two trials of four minutes each are administered, with a rest period between the trials. Several scores are obtained, based on the subject's performance in each trial separately, the combined trials, and the difference between trials.

Purdue Pegboard Test

The Purdue Pegboard Test is a standard instrument for measuring manipulative dexterity. It was included in the project test battery to predict the client's ability to perform a variety of workshop tasks and to provide possible clues for future vocational planning.

Self-Image Scale - "What Kind of a Person Am I?"

By and large, attempts at systematically relating workshop rehabilitation outcome to psychological test findings have been frustrating. Repeatedly, standard projective and clinical tests have failed to substantiate observed changes in work behavior and adjustment resulting from a rehabilitative workshop experience. It is at least conceivable that the tests measure stable, underlying psychodynamic variables which are relatively unaffected by more superficial changes in work behavior.

In an attempt at getting at immediate, conscious self-definitions of the clients, a brief self-image rating scale was constructed. This scale addresses itself substantively to self-perceptions around the role of hospital patient and the role of worker. It is based on the assumption that self-expectations and situational definitions may be important factors (among many others, to be sure) in determining work behavior.

The scale consists of 29 items and is self-administered.

Chicago Scale of Employability

The Scale of Employability is an instrument constructed at the

Chicago Jewish Vocational Service for predicting employment outcomes for handicapped persons seeking rehabilitation. It is based on Gellman's concept of the vocational pattern, a characteristic, integrated, and organized pattern which reflects an individual's personality structure and the manner in which his needs and desires are incorporated in work situations (3).

The Scale is composed of three separate scales, each of which has its own "total score" and each of which is analyzed separately. In our study only two of the three scales were used (Workshop and Counseling) since the third scale (Psychology) was still in a more exploratory phase of development.

The Workshop Scale is described below. The Counseling Scale is based on directly observable behavior and on information obtained in an interview situation. It was filled out by the project counselor at the time of the initial interview with the patient, prior to his entering the workshop program.

Stage 3 - Workshop Program

Chicago Scale of Employability - Workshop Scale

The Workshop Scale was filled out by the Project workshop counselor after the client's initial two weeks in the shop. It rates a variety of observed and inferred behaviors concerning adjustment to the work situation.

Stage 4 - Post-Workshop Planning

At this point two instruments were repeated to assess shifts resulting from the workshop experience. The two scales were: 1) Chicago Employability - Workshop Scale, and 2) Self-Image Scale "What Kind of a Person Am I?"

Discontinued Tests

Two tests were tried but discontinued after it was found that they were unsuited to the client population. These were the Strong Vocational Interest Blank and the California Personality Inventory. Both proved too difficult, both in reading level and conceptual level, for many of our clients.

CHAPTER III

RESULTS

In order to help the reader to evaluate the various aspects of the study, results will be examined under the following headings:

A. Critical Background Characteristics of Clients by "treatment groups"

The self-selection feature of the project resulted in 4 discrete client groupings, based on their degree of participation in the rehabilitation process. These groups are Workshop Graduates (n=76), Workshop Dropouts (n=22), Pre-Workshop Dropouts (n=13), and Rejects (n=35). This section will describe demographic, vocational and psychiatric characteristics of these 4 groups.

B. Rehabilitation Outcomes

Follow-up information will be presented regarding the clients' hospitalization and employment experiences following service through the project.

C. Predictions

One aim of the study was to determine the relevance to vocational rehabilitation of a number of tests and rating scales. This section will describe findings related to predicting rehabilitation outcomes by means of tests and scales.

A. Critical Background Characteristics of Clients by "treatment groups"

The following section describes some of the demographic, vocational and psychiatric characteristics of the four groups which emerged from the study design.

Table 2 presents selected population characteristics of the four treatment groups. The table indicates that the average age of the clients was about thirty years and that there were almost twice as many men as women in each group. Caucasians outnumbered Negroes approximately three to one. In religious makeup, each group consisted of roughly one-half Protestants, and one-third Catholics, with the rest being equally divided between Jewish and other denominations. In marital composition, the clients may be described as largely unattached, only ten percent being married at the time of the study. The largest majority

(70%) had never been married, and the rest were separated or divorced from their spouses. None of the differences between the groups on the above-mentioned variables proved statistically significant.[1]

TABLE 2

Age, Sex, Race, Religion and Marital Status of the Four Client Groups. (Percentages in parentheses)

INDEX	GROUP				
	Wkshp. Grads	Wkshp.Drpouts	Prpwkshp d'outs	Rejects	All Clients
Age					
Mean	31.00	30.90	29.00	33.25	31.34
S. D.	10.26	10.21	12.22	12.74	11.14
Sex					
Male	53 (70%)	14 (64%)	6 (46%)	22 (63%)	95 (65%)
Female	23 (30)	8 (36)	7 (54)	13 (37)	51 (35)
Totals	76	22	13	35	146
Race					
White	56 (74%)	17 (77%)	12 (92%)	27 (76%)	112 (77%)
Negro	20 (26)	5 (23)	1 (8)	7 (20)	33 (22)
Other	— (0)	— (0)	— (0)	1 (3)	1 (1)
Totals	76	22	13	35	146
Religion					
Protestant	37 (48%)	12 (54%)	6 (46%)	20 (56%)	75 (51%)
Catholic	26 (34)	7 (32)	6 (46)	13 (37)	52 (35)
Jewish	7 (9)	1 (4)	1 (8)	2 (6)	11 (8)
Other	6 (8)	2 (9)	— (0)	— (0)	8 (6)
Totals	76	22	13	35	146
Marital Status					
Single	56 (73%)	12 (54%)	9 (68%)	22 (63%)	99 (68%)
Married	9 (12)	2 (9)	– (0)	8 (23)	19 (13)
Sep. or Divorced	11 (14)	8 (36)	3 (23)	5 (14)	27 (18)
Widowed	— (0)	— (0)	1 (8)	— (0)	1 (1)
Totals	76	22	13	35	146

The educational achievement and socio-economic level of the client groups are summarized in Table 3.

[1] Unless otherwise indicated, the level of significance accepted in reporting the data is .05.

In general, differences between groups are small and none are statistically significant. The table shows that almost 60% of all clients did not graduate from high school. Only about 5% possessed a college education. In socio-economic status, about one-fifth of the group came from a poverty background, one-third from lower class and another one-third from middle-middle to lower-middle class parental homes. Less than 10% of clients enjoyed a privileged upper-middle to upper background.

TABLE 3

Educational Level of Clients and Socio-Economic Status of their Parental Families. (Percentages in parentheses)

Education and Socio. Econ. Level	GROUP				
	Wkshp. Grads	Wkshp. Drpouts.	Prpwkshp D'outs	Rejects	All Clients
Education					
College Completion	3 (4%)	1 (4%)	1 (8%)	2 (6%)	7 (5%)
H. School Completion	29 (38)	9 (41)	5 (38)	12 (34)	55 (37)
E. School Completion	28 (37)	9 (41)	5 (38)	12 (34)	54 (36)
Below Elem. School	16 (21)	3 (13)	2 (15)	9 (26)	30 (21)
Totals	76	22	13	35	146
Socio-Economic Level					
Upper-Middle & above	4 (6%)	3 (13%)	1 (8%)	2 (6%)	10 (7%)
Average or lower-middle	30 (39)	7 (32)	5 (38)	12 (34)	54 (36)
Lower	26 (34)	7 (32)	5 (38)	15 (43)	53 (35)
Poverty	16 (21)	5 (23)	2 (15)	6 (17)	29 (21)
Totals	76	22	13	35	146

The next three tables summarize the vocational history of the four groups.

Table 4 presents two indexes of past employment: (1) Degree of Past Employment, which roughly relates the extent of time worked to time available for working; (2) Percent of Last Ten Years Employed, which is an absolute measure, ignoring the availability factor. (Thus, a person who had been hospitalized continuously for the last ten years would be in the less than 10% classification.) The table indicates that the Workshop Graduates, as compared to the other three groups, had a slightly higher degree of past employment. This difference, when subjected to a 2 x 2 x 2 test (Workshop Graduates vs all others, half time or better employment vs less than half time) reaches the 10% level of confidence ($X^2 = 3.19$, d.f. = 1). No meaningful differences were noted in the Percent of Last Ten Years Employed. Over half the clients had extremely poor (or nonexistent) work records for the ten years preceding the study, and only about 20% had worked half the time or more.

TABLE 4

Employment History of the Four Client Groups.
(Percentages in parentheses)

INDEX OF EMPLOYMENT	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
1. Degree of Past Employment					
Full time employed	12 (16%)	6 (27%)	— (0%)	3 (9%)	21 (14%)
½ – ¾ time employed	18 (23)	2 (9)	3 (23)	3 (9)	26 (18)
Sporadic–less than ½ time	27 (35)	10 (46)	4 (30)	15 (43)	56 (38)
No significant employment	19 (25)	4 (18)	6 (46)	14 (39)	43 (29)
Totals	76	22	13	35	146
2. Percent of Last 10 Years Employed					
50% or more	12 (18%)	6 (30%)	1 (8%)	2 (8%)	21 (17%)
10% – 49%	20 (29)	5 (25)	4 (30)	5 (21)	34 (27)
Less than 10%	37 (53)	9 (45)	8 (61)	17 (70)	71 (56)
Totals	69*	20*	13	24*	126*

*Information was missing for cases not included in these distributions.

The clients' job stability is described in Table 5. On the average, clients had held three jobs in their past. One-third of the clients lasted less than one year on any of their jobs, while one client out of five maintained jobs of minimum five years duration. Differences between groups were not statistically significant.

TABLE 5

Job Stability of the Four Client Groups.
(Percentages in parentheses)

INDEX OF STABILITY	GROUP				
	Wkshp. Grads	Wkshp. Drpouts.	Prpwkshp d'outs	Rejects	All Clients
1. Total Number of Jobs Held					
$\bar{X}$	3.12	4.29	2.00	1.89	2.98
S. D.	2.54	2.82	1.89	2.42	2.63
2. Length of Longest Job Held					
5 Years or More	14 (24%)	5 (26%)	1 (10%)	2 (18%)	22 (22%)
1 – 4.9 years	26 (44)	4 (21)	4 (40)	7 (64)	41 (41)
Less than 1 year	18 (31)	10 (52)	5 (50)	2 (18)	35 (36)
Totals	58*	19*	10*	11*	98*

*Information was missing for cases not included in these distributions.

The occupational level of clients was generally low across groups, almost 50% falling into the unskilled or semi-skilled categories. Of the remainder, slightly more than half were skilled and white collar workers, while the rest were students. No differences between groups were noted. (Table 6)

TABLE 6

Occupational Level of the Four Client Groups.
(Percentages in parentheses)

OCCUPATIONAL LEVEL	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Upper white collar/professions	5 (7%)	1 (4%)	— (0%)	— (0%)	6 (4%)
Skilled/lower white collar	17 (22)	3 (13)	3 (23)	12 (34)	35 (24)
Unskilled/semi-skilled	40 (52)	15 (69)	5 (38)	11 (31)	71 (48)
Student/housewife	14 (18)	3 (13)	5 (38)	12 (34)	34 (23)
Totals	76	22	13	35	146

The next series of tables (numbers 7-10) portrays the premorbid and psychiatric course of the four client groups. Most of the variables dealt with were of necessity imprecise and global in nature. Ratings were based on information obtained from hospital case records and were made at the time of selection of the client into the project.

Table 7 presents two indicators of premorbid functioning: the level of responsibility assumed by the client and the presence of meaningful heterosexual relationships. While the Responsibility item was originally rated on a four step scale (from head-of-household through considerable, sporadic to none), for statistical analysis adjoining scale points were collapsed to yield a dichotomous rating. Heterosexual Relationships, an item from the Zubin-derived Prognostic Rating Scale #1, was likewise dichotomized. Inspection of Table 7 shows that a considerably higher proportion of workshop graduates were rated as having at one time assumed responsibility than was true in the other three groups. A X^2 test of the difference between workshop graduates and all other clients yielded a value of 5.94, significant at the 5% level of confidence. On the other hand, as far as heterosexual relationships are concerned, workshop graduates differed from non-graduates in an unexpected direction; significantly fewer of them had histories of heterosexual contacts ($X^2 = 5.38$, $p < .05$).

TABLE 7

Premorbid Functioning: Level of Responsibility and Presence of Heterosexual Relationships before onset of illness. (Percentages in parentheses)

Index of Premorbid Functioning	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Level of Responsibility					
Considerable	25 (33%)	3 (13%)	1 (8%)	6 (17%)	35 (24%)
Sporadic or None	51 (67)	19 (86)	12 (92)	29 (82)	111 (76)
Totals	76	22	13	35	146
Heterosexual Relationships					
Present	39 (51%)	16 (72%)	11 (85%)	23 (66%)	89 (61%)
Absent	37 (49)	6 (27)	2 (15)	12 (34)	57 (39)
Totals	76	22	13	35	146

One of the commonly used determinants of psychiatric prognosis is the duration of symptomatology prior to initial hospitalization. Zubin (14) suggests that two years seems to be the differentiating point between favorable and unfavorable outcomes. In this project, about a third of all clients showed symptoms of disturbance for less than two years before being hospitalized (Table 8). Bearing out Zubin's findings, a significantly higher proportion of workshop graduates than other clients fell into this category ($X^2 = 3.93$, $df = 1$, $p < .05$).

TABLE 8

Duration of Symptomatology Prior to Initial Hospitalization. (Percentages in parentheses)

DURATION	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Up to Two Years	30 (40%)	7 (32%)	2 (15%)	7 (20%)	46 (32%)
Over Two Years	45 (60)	15 (68)	11 (85)	27 (80)	98 (68)
Totals	75*	22	13	34*	144*

*Information was missing for cases not included in these distributions.

Once hospitalization occurred, however, patterns did not differ between groups. On the average, initial hospitalization was around age 24 and was the first of several. At the time of the study, our clients had spent over four years time in aggregate hospitalizations. In terms of the length of their current hospitalization, groups likewise showed little variation. For about a fourth of the clients, the current stay was brief, less than one year, while another fourth could well be considered chronic, in that current stay was over five years in duration. (Table 9)

TABLE 9

Pattern of Psychiatric Hospitalization
(Percentages in parentheses)

INDEX	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Age at 1st Hospitalization					
$\bar{X}$	24.6	24.3	23.7	25.7	24.7
S. D.	8.6	9.2	8.4	11.4	9.4
Duration of all Psychiatric Hospitalizations (In Months)					
$\bar{X}$	56.5	42.7	56.8	60.6	55.4
S. D.	49.3	35.4	55.0	62.6	51.9
Number of Psychiatric Hospitalizations					
$\bar{X}$	2.7	2.6	2.9	3.4	2.9
S. D.	1.4	1.3	2.3	2.8	1.9
Duration of Present Hospitalization					
Up to 1 Year	16 (21%)	5 (23%)	4 (30%)	11 (31%)	36 (25%)
1 – 5 Years	43 (56)	12 (54)	6 (46)	15 (43)	76 (52)
Over 5 Years	17 (22)	5 (23)	3 (23)	9 (26)	34 (23)
Totals	76	22	13	35	146

Table 10 presents psychiatric diagnosis in relation to project group. Several points may be noted:

1. Over 80% of clients referred to the project were diagnosed psychotic; of those actually receiving service, 85% carried a primary diagnosis of psychosis. Thus the project clearly dealt largely with this highly disturbed type of psychiatric population.

2. Quite by coincidence, equal numbers of paranoid schizophrenics and chronic undifferentiated schizophrenics were referred. The progress of these two groups through the project differed markedly, however (Table 10). Of the 50 paranoid patients referred, 30 completed the workshop, but only 22 of the 50 chronic schizophrenics did as well. Adjusting these figures to take into account the rejected group, a workshop graduation rate of 73% for paranoids vs 55% for chronics is obtained. As a group, the 20 patients with other psychotic disorders closely follow the paranoid group--their workshop graduation rate equals 73%. (By comparison, the neurotic clients achieved a rate of 83% and personality disorders 85%.)

3. Consistently, more of the chronic undifferentiated than the paranoid schizophrenic patients became dropouts at each stage. With the small numbers involved in each group, the differences do not achieve statistical significance. However, the trend is worth noting.

4. The only clients who failed to complete the workshop were classified as psychotic. Once started, all clients with neurotic or personality disorders completed the eight week program. 22 of the 82 psychotic clients were unable to sustain this effort.

TABLE 10

Diagnostic Composition of the Four Client Groups.
(Psychiatric Diagnosis at time of selection.)
(Percentages in parentheses)

DIAGNOSIS	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Psychotic Disorders	60 (79%)	22 (100%)	10 (77%)	28 (80%)	120 (82%)
Psychoneurotic Disorders	5 (7)	— (0)	1 (8)	— (0)	6 (4)
Personality Disorders	11 (14)	— (0)	2 (15)	3 (9)	16 (11)
Chronic Brain Disorders	— (0)	— (0)	— (0)	4 (11)	4 (3)
Totals	76	22	13	35	146
Psychotic Disorders					
Paranoid Schiz.	30	8	3	9	50
Chronic, Undifferentiated	22	12	6	10	50
Other Psychoses	8	2	1	9	20

B. Rehabilitation Outcomes

1. Employment Status

Table 11 presents the official DVR status of clients six months following their completion of the workshop experience (or its equivalent). Altogether, it should be noted, one-third of all clients referred to the project could be considered rehabilitated or actively involved in rehabilitative efforts. Analysis by project treatment reveals marked differences between groups. Almost half of workshop graduates were rehabilitated or moving toward this goal; in contrast, less than one-fifth of non-graduates held this positive DVR status at the 6-month follow-up. A X^2 test of this difference is significant at the 1% level of confidence ($X^2 = 13.75$, d.f. = 1).

TABLE 11

DVR Status of Clients Six Months following Workshop Experience. (Percentages in parentheses)

DVR STATUS (Code in parentheses)	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
Positive					
Rehabilitated – Closed (12)	20 (26%)	3 (14%)	–– (0%)	4 (11%)	27 (18%)
Employed or in Training (7 or 5)	6 (8)	1 (4)	2 (15)	1 (3)	10 (7)
Ready for Employment (6)	10 (13)	–– (0)	– - (0)	1 (3)	11 (8)
Negative					
Interrupted (8)	8 (10%)	–– (0%)	–– (0%)	4 (11%)	12 (8%)
Unemployed – Closing (13)	7 (9)	2 (9)	1 (8)	1 (3)	11 (8)
Closed from referral (22–28)	25 (33)	16 (73)	10 (77)	24 (69)	75 (51)
Summary:					
Positive	36 (47%)	4 (18%)	2 (15%)	6 (17%)	48 (33%)
Negative	40 (52)	18 (82)	11 (85)	29 (83)	98 (67)
Totals	76	22	13	35	146

Further analysis of the 76 clients who finished the workshop suggests that performance in the shop was significantly related to ultimate rehabilitation outcome. Table 12 presents DVR status of workshop graduates in relation to their final workshop evaluation. The data show that whereas over 60% of positively evaluated clients are in positive rehabilitation status with DVR, the same is true for less than 30% of the negatively evaluated clients. This difference yielded a X^2 value of 9.01, significant at the 1% level of confidence.

TABLE 12

DVR Status of Workshop Graduates Six Months following Workshop Experience, by Final Workshop Evaluation; (Percentages in parentheses)

DVR STATUS	Final Workshop Evaluation			
	Positive		Negative	
	Placeable	Marginal	TSMPL	Unemploy.
Positive				
Rehabilitated – Closed	6	6	2	6
Employed or in Training	2	2	—	2
Ready for Employment	6	4	—	—
Negative				
Interrupted	4	2	1	1
Unemployed – Closing	1	3	1	2
Closed from referral	2	2	3	18
Summary:				
Positive	14 (67%)	12 (63%)	2 (29%)	8 (28%)
Negative	7 (33)	7 (37)	5 (71)	21 (72)
Totals	21	19	7	29

2. Hospital Status

A second, indirect measure of rehabilitation experience was obtained by checking clients' official hospital status 6 months and 12 months following workshop completion. Table 13 presents these data. Inspection of the table shows that at both followup times a considerably higher percentage of workshop graduates than non-graduates were out of the hospital. Since discharge rates across groups appeared fairly similar, the differences appear mainly in the size of the family care-outpatient category.

TABLE 13

Official Hospital Status, 6 and 12 months following the Workshop Experience, of the Four Client Groups. (Percentages in parentheses)

HOSPITAL STATUS	GROUP				
	Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
1st Followup					
Inpatient	45 (58%)	17 (77%)	11 (84%)	26 (74%)	99 (68%)
Family Care/Outpatient	24 (32)	3 (13)	1 (8)	6 (17)	34 (22)
Discharged	7 (9)	2 (9)	1 (8)	3 (9)	13 (7)
Totals	76	22	13	35	146
2nd Followup*					
Inpatient	28 (58%)	11 (69%)	9 (81%)	19 (72%)	67 (66%)
Family Care/Outpatient	15 (31)	2 (12)	1 (9)	4 (15)	22 (22)
Discharged	5 (10)	3 (19)	1 (9)	3 (12)	12 (12)
Totals	48	16	11	26	101

*Since date analysis proceeded immediately upon termination of the project, not all clients were included in the second follow-up survey.

A 2 x 2 X^2 test of these findings is significant at the 5% level of confidence for the six month followup, but does not achieve significance (due to the small numbers involved) for the twelve month period.

TABLE 14

X^2 Tests of the Differences in Hospital Status between Workshop Graduates and Non-graduates at two Follow-up Periods.

	Workshop Graduates	Non-Grads.	All Clients	X^2	P
1st Followup					
In Hospital	45	54	99	4.58	< .05
Out of Hospital	31	16	47		
Both	76	70	146		
2nd Followup*					
In Hospital	28	39	67	1.99	> .10
Out of Hospital	20	14	34		
Both	48	53	101		

*See footnote, Table 13.

3. Number of Weeks Out of Hospital

Another index of rehabilitation success, related to hospital status, is the patient's ability to sustain himself, physically and emotionally, outside of the institutional structure. To measure this achievement for our clients, the actual time spent out of the hospital was computed at each followup point. Table 15 summarizes these findings by project group. Although a t-test of the mean difference between workshop graduates and non-graduates just misses achieving significance, it may be noted that (1) at both followup periods, graduates spent more time out-of-hospital than non-graduates; and (2) the difference between graduates and non-graduates increases over time (within the project period). Thus, the effect is durable and even more marked after one year than in the first six months.

TABLE 15

Time (in weeks) spent Out-of-hospital between the end of the Workshop Experience and 2 Follow-up Periods.

		GROUP				
		Wkshp. Grads	Wkshp. Drpouts	Prpwkshp d'outs	Rejects	All Clients
1st Followup						
	n_1	76	22	13	35	146
	$\bar{X}_1$	7.3	3.8	4.6	5.2	6.0
	S. D_1	8.9	6.7	8.4	9.0	8.7
2nd Followup*						
	n_2	48	16	11	26	101
	$\bar{X}_2$	15.9	10.1	9.8	9.8	12.8
	S. D_2	17.7	15.2	17.6	16.2	17.2
Difference						
	$\bar{X}_2 - \bar{X}_1$	8.6	6.3	5.2	4.6	6.8

* See footnote, Table 13.

C. Predictions.

1. Prognostic Rating Scale #1

This scale , it will be recalled, is based on an extensive survey of the psychiatric literature by Zubin and consists of seventeen discrete items (several of which are divided into sub-items) relating to premorbid and diagnostic variables. These items were individually tested by means of X^2 against the following criterion of post-hospital vocational adjustment six months after workshop completion (or equivalent time interval):

1. Continuous employment on one or two jobs
2. Worked most of the time but on two or more jobs
3. Worked at least half the time
4. Worked one month (= DVR closure)
5. Only occasional and/or temporary work
6. Worked only in sheltered employment (CW, own family, etc.)
7. Did not work at all
8. Not applicable - continuously in hospital

For purposes of statistical treatment, the follow-up criterion was dichotomized into good vocational adjustment (1-4) vs poor vocational adjustment (5-8).

Of the 28 items and sub-items in the scale, the only one to achieve statistical significance was the item dealing with quality of thinking. Good vocational adjustment was more often achieved by clients exhibiting logical thinking than by those with illogical thought processes. A X^2 test of this difference is significant at the 5% level of confidence (Table 16).

Three other items approached statistical significance: appropriateness of affect, intactness of thought processes and absence of autism. In each of these, the observed trend was in the expected direction (good vocational adjustment being associated with improved psychiatric symptomatology). All other items in this scale failed to differentiate between positive and negative outcomes. (Table 16)

TABLE 16

Selected Items from Progpostic Rating Scale #1 by Vocational Adjustment of all Clients Six Months following Workshop Completion.

ITEM	Vocational Adjustment			X^2	P
	Good	Poor	All Clients		
Thinking					
Logical	10	35	45	4.70	< .05
Illogical	7	85	92		
Both	17	120	137*		
Affect					
Appropriate	10	39	49	3.52	< .10
Inappropriate	7	82	89		
Both	17	121	138*		
Thought Processes					
Intact	9	36	45	2.83	< .10
Scattered	8	87	95		
Both	17	123	140*		
Autism					
Absent	7	23	30	3.32	< .10
Present	9	93	102		
Both	16	116	132*		

*All data for Prognostic Rating Scale #1 were obtained from the patient's hospital case record; where information was insufficient for judging an item such item would be left blank. Hence, the variable n (out of a possible 146).

2. Prognostic Rating Scale #2.

This scale consisted of staff members' predictions of future success of clients (both in and following the workshop) based on staffing interviews. Since attendance at staff meetings varied somewhat from week to week and considerably over the length of the project, no attempt was made to ascertain the accuracy of prediction of specific individuals; rather, for each client, predictions were summed across raters and averaged, yielding an average staff prediction. Two predictions were attempted:

(1) Will the client complete the JVS-CW program? Scaled responses ranged in four steps from "will never start in the shop" to "will complete program". These ratings were tested against actual outcome (from pre-workshop dropout to graduates) and were found to be non-predictive (Pearson r = -.03).

(2) Client's post-workshop vocational adjustment? Responses were scaled in seven steps from "continuous employment" to "will not work at all". This item was tested against the appropriate item of vocational adjustment at two follow-up periods and was found to be non-predictive. (Six months follow-up Pearson r = .12; twelve month follow-up, Pearson r = -.11).

3. Psychological Tests.

The ability of psychological instruments to anticipate vocational rehabilitation performance was tested against a variety of outcome criteria, both proximally (workshop performance) and more distally (six and twelve month follow-up vocational adjustment). Thus, comparisons were made between:

(1) positively evaluated and negatively evaluated workshop graduates (see below)

(2) workshop graduates and workshop dropouts

(3) good vocational adjustment and poor adjustment at follow-up

Since testing was done at Stage 2 (Workshop Preparation), data are available only on the 98 clients who started in the Workshop. Rejects and Pre-workshop Dropouts were not tested and hence are not included in this analysis. Without exception, the tests used in this project failed to predict vocational outcomes of clients. Illustrative of the type of results obtained is Table 17, which presents test results of the 76 workshop graduates in relation to their final workshop evaluation. This global evaluation was based on such factors as overall workshop performance, skill level and psychiatric status and yielded ratings of employability (from "placeable" through "marginally placeable", "sheltered work-terminal employable" to "unemployable"). For purposes of presentation, the four scale employability ratings are collapsed into two dichotomous ratings, positive vs negative final workshop evaluation. On the WAIS and the Cohen Conceptual Thinking Test, positively evaluated clients scored slightly higher than the less successful clients. The opposite is true on Reversed Digits, where the unsuccessful clients outscored successful ones. Mixed results are obtained with the Purdue Pegboard Test. None of the differences found are significant, however.

TABLE 17

Relationship between Scores on Psychological Tests and Final Workshop Evaluation.

TEST	Final Workshop Evaluation				t(2)
	Positive(1)		Negative(1)		
	$\bar{X}$	S. D.	$\bar{X}$	S. D.	
Wechsler Adult Intelligence Scale					
Verbal IQ	99.3	14.7	97.4	14.4	0.6
Performance IQ	93.6	12.3	91.4	16.4	0.7
Full Scale IQ	96.6	12.9	94.4	15.3	0.7
Verbal IQ – Performance IQ	5.7	12.4	5.9	8.7	0.1
Cohen Conceptual Thinking Test					
Series A	27.9	16.0	24.4	14.3	1.0
Series B	37.8	12.0	34.2	16.8	1.0
Reversed Digits Test					
Trial 1	96.0	24.1	105.0	34.7	1.3
Trial 2	119.5	31.5	132.1	46.0	1.4
Purdue Pegboard					
Right hand	14.4	1.8	14.4	2.1	0.0
Left hand	13.2	1.5	13.4	2.3	0.4
Both hands	11.1	1.6	10.8	1.8	0.7
Assembly	26.7	3.5	27.8	5.4	1.1

(1) N = 40 positive + 36 negative = 76 Workshop Graduates.

(2) None of the t'values are significant.

4. Self-Image Scale - "What Kind of a Person Am I?"

This scale was constructed by the research staff and administered twice, before workshop entry (Stage 2) and upon completion of the workshop (Stage 4). Hence, only the 76 workshop graduates were retested. Data were analyzed in a number of ways:

(1) Shifts from pre- to post-tests for the same individuals (change scores)

(2) Comparison of positively evaluated clients ("placeable") and negatively evaluated clients ("unemployable")

(3) Comparison of workshop dropouts and graduates

(4) Comparison of good vocational adjustment vs poor vocational adjustment at follow-up

Statistical analysis of the scale proved difficult and unrewarding - although responses to each item were scaled in a roughly continuous fashion, test items themselves were qualitatively different from each other. Thus, inspection of the data revealed no patterns of scores which related systematically to the above variables. The scale's main contribution was in its clinical usage, by providing workshop counselors insights into their clients' conscious attitudes and expectations in a number of work-relevant areas.

5. Chicago Employability Scale

Table 18 summarizes the relationships obtained between scores on the Chicago Counseling and Workshop Scales and the final workshop evaluation. It will be recalled that while the Counseling Scale was completed before the start of the Workshop, each client was rated twice on the Workshop Scale--after the client's initial two weeks in the shop and again at the conclusion of the eight week experience. Overall scores for these two ratings were essentially consistent (Pearson r = .77). Examination of Table 18 indicates that both scales (and all subscales comprising the Workshop Scales) are significantly related to final Workshop Evaluation.

TABLE 18

The Relationship between Chicago Counseling and Workshop Scales and Final Workshop Evaluation.

SCALE	Final Workshop Evaluation				t
	Positive		Negative		
	$\bar{X}$	S. D.	$\bar{X}$	S. D.	
1. Chicago Counseling	38.5	5.2	34.1	5.9	1.96(1)
2. Chicago Workshop-Initial					
Mobilize Energy	55.8	10.7	38.4	13.6	3.63(2)
Tolerate Pressure	58.0	9.4	46.1	14.5	2.44(1)
Interpersonal relations	53.4	6.6	40.5	9.2	4.78(2)
Functioning level	52.0	7.3	38.7	12.6	4.08(2)
Overall converted Score	54.3	6.3	40.9	9.5	4.41(2)
3. Chicago Workshop-Final					
Mobilize Energy	59.3	7.5	36.7	9.6	5.57(2)
Tolerate Pressure	59.9	7.9	42.6	11.8	4.71(2)
Interpersonal relations	56.3	6.1	38.1	7.7	5.58(2)
Functioning level	55.0	5.7	36.3	10.2	4.65(2)
Overall converted Score	57.0	4.5	38.4	6.8	5.86(2)

(1) p. < .05

(2) p. < .01

In all instances, the differences between scores were in the expected direction, i.e., workshop graduates who were rated employable received higher scale (and subscale) scores than graduates rated unemployable.

Table 19 presents the relationships between the Counseling and Workshop Scales and the more distant outcome criterion--vocational adjustment six months following completion of the workshop. Examination of this table reveals that of the two scales, only the Counseling Scale is related, to a statistically significant degree, to vocational adjustment at the time of followup.

TABLE 19

The Relationship between Chicago Counseling and Workshop Scales and Vocational Adjustment at Six Months' Follow-up.

SCALE	Vocational Adjustment				t
	Positive		Negative		
	$\bar{X}$	S. D.	$\bar{X}$	S. D.	
1. Chicago Counseling	39.7	5.3	35.1	4.2	2.08(1)
2. Chicago Workshop-Initial	45.6	12.1	45.9	10.8	.69
3. Chicago Workshop-Final	53.6	11.6	46.4	11.1	1.02

(1) p. < .05

CHAPTER IV

DISCUSSION

Characteristics of Clients

In order to establish a meaningful point of departure for discussing the results of the project, it may be helpful to present a brief composite picture of the "typical client." In reviewing this composite of data presented in Section A of Chapter 3, it should be recalled that the project explicitly addressed itself to clients who presented "perplexing" problems with respect to suitability for vocational rehabilitation services. Hence by design clients feasible for regular services were excluded, and only clients of dubious employability, i.e., who normally would have been rejected as ineligible for service, were considered for the project. Whether or not and to what degree the project succeeded in selecting such clients may be judged by the following:

The average client referred to the project was a 30-year-old, white male from a lower-class to lower-middle-class socio-economic background. A high school drop-out, he had no military service record but showed a highly unstable work history. When he worked, he was typically employed at a level of unskilled or semi-skilled labor and he had held an average of three short-term jobs; during the last ten years (before referral to the project) he had typically worked less than one year.

In the personal sense, clients presented a picture of marginal life concerns. Family responsibilities, in terms of providing for or helping to provide for others, were minimal. Although some dating had occurred, most clients at the time of the study were unattached, generally having remained single.

This paucity of personal and vocational achievement is not surprising in light of the pattern of mental illness and hospitalization. The "typical" client was hospitalized for the first time around age 25, after having exhibited symptoms of emotional disturbance for more than two years (actual time was not ascertained). Since that time and up to the start of the project, all but approximately six months had been spent in hospitals. The latest (current) hospital stay had been for over well one year.

Critical Differentiating Characteristics

In terms of the stated objective of "delineating critical characteristics of this population which differentiate between successful and unsuccessful rehabilitative outcomes" (see Purpose, Chapter I), the

results are limited. Of the host of demographic and social-vocational background variables investigated, only a few differentiated the successful workshop graduate from the above composite. In background the graduates did show a somewhat greater assumption of responsibility for their families (e.g., functioning as head of household) than did non-graduates. They also tended to demonstrate a more continuous pattern of past employment. Lastly, their records contain fewer indications of heterosexual contacts.

In clinical features as well, few differences between successful and unsuccessful clients were noted. The most meaningful difference relates to psychiatric diagnosis, in that nonpsychotics succeeded better than psychotics. Furthermore, within the latter category, a difference in success-rates is noted between chronic undifferentiated schizophrenics and other psychotics, with chronics showing the least favorable rate of success. A second finding was in the duration of symptomatology prior to initial hospitalization, with successful clients showing more acute onsets.

With the exception of the finding on heterosexual experiences (which is frankly a puzzling one) the obtained differences appear to fall into a pattern. Both in terms of premorbid functioning and onset and type of psychopathology, the results suggest a self-selecting feature of the project. In effect clients with more adequate levels of ego integration chose to proceed to graduation. Although the eight-week rehabilitation program was conceived as a supportive and sheltered experience, designed to ease the client's transition from institutional care to independent living, it is clear that for many clients it represented a rather abrupt change. It must be recognized that even this benign work environment made heavy demands on its participants; new instrumental skills were required in the process of getting to and from the workshop, being on time, following directions, attending to quantity and quality criteria, etc. No less taxing were the emotional and attitudinal demands on clients, for symptom control, social interaction, and management of anxiety, to name but a few.

Predictions

A second goal of the project concerned the prediction of rehabilitation outcome by means of a variety of tests and selection instruments. In general, the negative results corroborate the findings of numerous other studies, which have reported no relationship between psychological test variables and vocational adjustment of psychiatric patients (JVS Essex County, 1963; Lowe, 1967). Whether defined in terms of short-range workshop behavior or more distant follow-up criteria, psychological measurements were unable to differentiate between successful and unsuccessful clients. This was true of both standard

scales, such as the WAIS or the Purdue Pegboard, and also of less established tests. That relatively little is known concerning the pathology of work behavior was further suggested by the fact that pooled clinical judgments of trained staff proved similarly non-predictive.

By far the most promising approach to measuring the complex set of behaviors which constitute vocational adjustment appears to be the further development and use of special instruments designed for the purpose. One such instrument - the Chicago Employability Scale - was the only instrument which showed modest but statistically significant relationships with the vocational criterion.

The Chicago Scale of Employability for Handicapped Persons is made up of three subscales, only two of which were used in this project: the Counseling Scale and the Workshop Scale. Significant correlations with vocational behavior were obtained on both. Methodologically, some question regarding the independence of scores on the Workshop Scale may be raised, since both the scale ratings and the overall workshop evaluation (criterion ratings) were done by the same counselor and were probably based on the same workshop observations. It is therefore more interesting to note that the Counseling Scale, which is not open to such criticism, correlated not only with workshop evaluations but also with the six-month follow-up criterion; the Workshop Scale, however, failed to hold up over time. A factor analytic study of the Employability Scale (JVS, Chicago, 1963) lists the following factors for the Counseling Scale: recent work history, appropriateness of job demands, interpersonal competence, language facility, prominence of handicap, and ethnic-racial identity. Factors found in the Workshop Scale were: attitudinal conformity to work role, speed of production, maintenance of quality, acceptance of work demands, interpersonal security, clerical ability.

The results of the project suggest that characteristics which are readily assessed in an office setting (i. e. impressions gained in a job interview) may be more directly related to success in employment for psychiatric patients than traits which become apparent only in the work situation itself.

The Rehabilitation Program

From a service perspective, the success of the program may be gauged by the fact that almost half of the workshop graduates were either rehabilitated or in an active rehabilitation status six months following their termination from the shop. Stated another way, three out of every four clients in the project who reached this goal were workshop graduates. Without specifying the exact nature of the

relationship, it is clear that being a workshop graduate greatly increased a client's probability of rehabilitation. Whether this was a consequence of self-selection of clients who persisted to graduation or of factors in the rehabilitation program cannot be determined in the design of this research. Nevertheless, it is useful to describe the programmatic features operating in the shop which may well have contributed to the differential success of graduates.

It will be recalled that, instead of setting up a separate unit for the project, clients were deliberately injected into an ongoing workshop employing clients with diverse handicaps, backgrounds and life styles. At any one period, this population was likely to include a group of geriatric clients, whose stay in the shop was terminal, a number of clients with various physical disabilities and a small number of mentally retarded individuals.

Although both staff and other clients needed a period of adjustment to the Northville clients (as they became known in the shop), initial fearfulness and reservations disappeared with the discovery that psychiatric clients were not that "different." In time, instances of fairly disturbed, even bizarre, behavior were tolerated, since they usually did not prove dangerous to others. On the rare occasions when serious disruptions did occur, they were handled with calm, matter-of-fact staff intervention, designed to minimize the contagious effect on others and the interruption of the ongoing operation.

The small number of project clients in the workshop at any one time (no more than six to eight) made it easier for them to become more fully involved in the sub-culture of the shop. Mixing with non-project clients was actively encouraged by the staff through shared work station assignments, during breaks, etc. This integration appeared to be of great benefit to the patients. The psychiatric patients seemed to obtain a good deal of satisfaction and reassurance from the fact that they were being trusted as equals in this setting. In addition, some of them were "adopted" by the old-timers who took a friendly, quasi-parental interest in their vocational and educational careers. At the same time, these older clients were instrumental in setting (no doubt for their own psychodynamic reasons) an atmosphere which discouraged acting out sick roles and which promoted reality-oriented, work-appropriate behavior.

In "The Myth of Sisyphus (2)," the protagonist is condemned to eternally roll his rock up a mountain, only to have it roll down again. Camus makes the observation that nothing is as demoralizing as endlessly performing meaningless tasks. To be truly rehabilitative, work has to have meaning to the client, both in terms of current functioning and future goals. As an agent of change, work has to afford a client

opportunities to make mistakes and to correct them, to test out strengths and weaknesses, to practice old habits and acquire new ones. In short, as a rehabilitation tool work has to be part of an overall plan which includes other components as well, such as medication, counseling, placement, etc.

A favorable staffing ratio permitted the program to function in a highly individualized, clinically oriented fashion. Operationally, this meant attending to work assignments and client responses to them with the same consideration for structure and content as is usually accorded more traditional types of therapy. Similarly, placement became part of the counselor's overall responsibilities. With free access to the JVS placement resources, including extensive employer files and cooperation of the placement specialist, the project counselor often could secure employment even for difficult-to-place clients. Not in all cases was the match between client characteristics and job requirements as perfect, however, as in the following selected case study: The client was a 28 year old single white woman with a diagnosis of psychopathic personality, amoral type. She had had a long history of sexual acting out, including charges of prostitution. After the client gave birth to two illegitimate children her mother eventually had her committed to the hospital. In the workshop she was described as a woman of average intelligence, with extremely low self regard and seductive in her dealings with others. Although she protested having no work skills worth mentioning, she was a fair power seamstress and with some additional training was eventually placed in a small pants factory. At the time of the six month followup (the last recorded contact) she was successfully employed in sewing on zippers on men's trousers!

Limitations of the Service

In terms of scope of service, one of the most serious limitations was in availability of after-care facilities. Although social service representatives cooperated fully in the clinical team, most of their resources were concentrated at the hospital itself and proved of limited value to the discharged or family-care patient. A number of studies (e. g. Brockhaven et al (1), Freeman & Simmons (6)) have noted that, since work is a highly structured activity and imposes less stress on interpersonal relationships, it is often the last area to suffer from psychological decompensation. Instead it is in the sphere of community and social adjustment that the first signs of relapse are noticed. In corroboration, it was noted over and over again that clients, although successful in employment, were unable to sustain their gains because of extra-vocational problems. These were largely social-recreational in nature; holidays and weekends were particularly difficult, since most clients lived lives of isolation and loneliness. Family contacts were

non-existent or tenuous and no facilities existed in the community to maintain the client, such as day centers or half-way houses.

Limitations of the Research

The methodological problems facing systematic studies of this type have been amply summarized in the literature (e.g. PEP). Many of them were true of this study as well. Some of the major limitations have already been detailed, such as the lack of rigorous control groups. Only brief mention need be made of further difficulties:

1. The extreme variability in the adequacy and completeness of hospital cumulative records made much data collection a hit-or-miss affair. This was especially true of historical, premorbidity information. Many of the variables which tapped this source (e.g. demographic characteristics, Prognostic Rating Scale #1) were thus of questionable, and, more seriously, indeterminate validity and reliability. The inconsistent, often contradictory diagnostic notations were another case in point.

2. In any project which extends over a number of years, staff turnover must be expected. This can result in disruptions of service and research functions, whether through lack of indoctrination of new staff members to the overall objectives, misinterpretation of specific details or even interpersonal difficulties. In this project, several staff changes at both counseling and supervisory level were unavoidable. Although any change adds a new dimension to a situation, these staff changes did not appear to significantly alter the nature of the project.

CHAPTER V

SUMMARY & CONCLUSIONS

This project explored the feasibility for vocational rehabilitation of a perplexing group of patients awaiting separation from a state mental hospital. The patients were of dubious employability, and under regular circumstances would not have qualified for service by the Michigan Department of Vocational Rehabilitation.

The project design may be represented as a series of sequential stages through which patients passed, with attrition taking place at each stage. 146 patients were referred to the Detroit J. V. S. - C. W. from Northville State Hospital and from the Lafayette Clinic, the two cooperating state hospitals. At an initial staffing 35 patients were eliminated from further consideration as either vocationally placeable through regular DVR services or psychiatrically not ready to benefit from the project. Of the remaining 111 patients who were accepted for project service, 13 dropped out during the period of psychological testing and preparation for workshop entry. Thus a total of 98 patients entered the workshop program proper. The program lasted for eight weeks and provided work adjustment rather than specific skill training. It consisted of a highly individualized, focused rehabilitation plan for each client, centering around work assignments in the shop, but including also regularly scheduled counseling interviews, group counseling sessions, frequent staffings, and coordination with hospital personnel.

76 of the 98 patients who began the workshop program completed it. Subsequently, services were provided tailored to individual need, involving job placement, referral for schooling or training, or planning for continued hospitalization. Follow-up information was obtained on all 146 patients six months following workshop completion (or its equivalent for those clients who did not reach this stage). A second follow-up twelve months following workshop completion reached a majority of clients.

Results

Major results of the study may be summarized as follows:

1. Graduation from the workshop greatly increased a client's probability of vocational rehabilitation. Almost half of the graduates were rehabilitated or moving towards this goal; in contrast, less than 1/5 of non-graduates held this positive DVR status at the six-month follow-up.

2. Performance in the workshop also was positively related to vocational rehabilitation. Over 60% of graduates receiving positive work evaluations were rehabilitated or moving toward this goal; of graduates receiving negative work evaluations, less than 30% held this DVR status at the six month follow-up.

3. With few exceptions demographic and social-vocational background variables failed to differentiate workshop graduates from non-graduates. Differences were noted in greater assumption of family responsibilities by graduates, a more continuous pattern of past employment and fewer indications of heterosexual contacts.

4. Psychiatric diagnosis was related to rehabilitation success, in the direction of favoring non-psychotic patients. Within the psychotic category chronic undifferentiated schizophrenics tended to show least favorable success rates. Further, successful clients showed more acute onsets of symptomatology.

5. With one notable exception none of the psychological tests used in this study proved predictive of future vocational performance, either in the workshop or at time of follow-up. The exception was the Chicago Scale of Employability for Handicapped Persons, one of whose major subscales (Counseling) correlated both with workshop evaluation and vocational adjustment six months hence.

6. Staff impressions of clients, based on brief clinical interviews at the hospital, also proved non-valid predictors of subsequent vocational performance.

7. Many patients, while accommodating successfully to the demands of the workshop and later employment, experienced major difficulties in other spheres of community adjustment. Absence of social-recreational outlets, in particular, often appeared to result in relapses requiring rehospitalization.

Conclusions

The following conclusions are tentatively offered:

1. Many psychiatric patients who are currently regarded as "too severely disabled" to benefit from vocational rehabilitation services are nevertheless capable of utilizing such help, given proper planning and sufficient resources. Depending on the availability of services and priorities governing their allocation, Michigan DVR may well want to consider lowering feasibility requirements for psychiatrically disabled clients, to include some currently regarded as "unfeasible" individuals.

2. The prediction of vocational rehabilitation performance for clients of the sort here studied is as yet highly unreliable. Although clinical features, such as diagnosis and onset of symptomatology, appear to play a part in the overall vocational adjustment of psychiatric patients, neither trained clinical staff evaluations nor standard psychological tests proved capable of adequately assessing the potential for such adjustment. A more promising approach appears to lie in the further refinement of special instruments designed for that purpose, such as the Chicago Scale of Employability. Until such prediction becomes more accurate, there is no professional reason to deny routine rehabilitation services at discharge to any psychiatric patient who requests such help. For the time being, and from a purely pragmatic point of view, self selection (such as is implied in such a request) would appear to provide the best assurance of maximizing rehabilitation opportunities for discharged patients.

3. A clinically conceived, individualized workshop program appears to be a highly useful facility for the psychiatric patient returning to the community. Serving as a bridge between the protected hospital environment and independent life in the community, it also provides both valuable work adjustment training and an opportunity for accurate assessment of vocational potential. At the same time the social needs of the chronic patient deserve recognition: a full spectrum of transitional facilities, including halfway houses, day or night hospitals, and social-recreational clubs, would go far in consolidating the gains made in the workshop.

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APPENDIX - FORMS

	Page
1. Prognostic Rating Scale #1	49
2. Prognostic Rating Scale #2	53
3. "What Kind of a Person Am I" Self-Image Scale.	54
4. Research Data Sheet	59
5. Follow Up Survey	65

JEWISH VOCATIONAL SERVICE-COMMUNITY WORKSHOP 229 Gratiot Avenue, Detroit, Michigan 48226

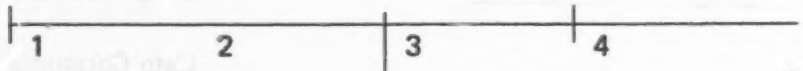
RESEARCH PROJECT RD–505

SELECTION COMMITTEE PROGNOSTIC RATING SCALE # 1

NAME OF CLIENT _____ RATER _____

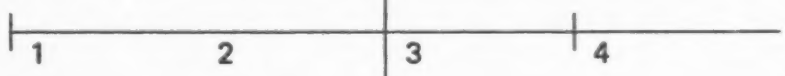
DATE _____

1. DURATION OF ILLNESS PRIOR TO HOSPITALIZATION



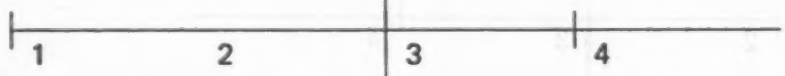
Under 2 years — 2 years or more

2. ONSET OF ILLNESS



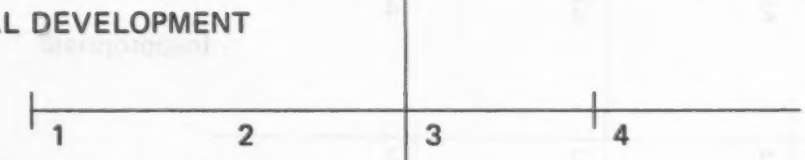
Sudden — Gradual

3. PRE-MORBID PERSONALITY

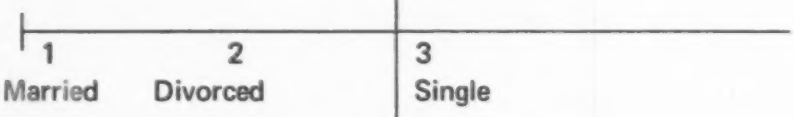


Extroverted and/or Cyclothymic — Introverted and/or Schizoid Shut-in

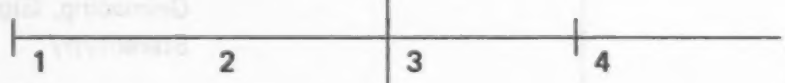
4. PSYCHOSEXUAL DEVELOPMENT



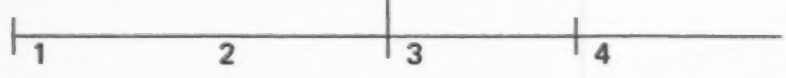
Presence of hetero-sexual relationships — Absence of hetero-sexual relationships



5. PRE-MORBID SOCIAL AND WORK HISTORY

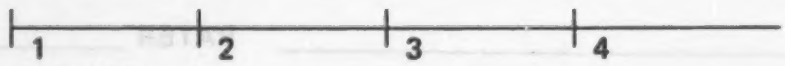


Good Social History — Poor Social History



Good Work History — Poor Work History

6. **PRECIPITATING FACTORS**



Present — Absent

7. **DIAGNOSTIC CATEGORIES**

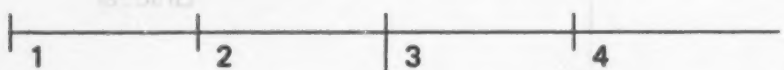
Catatonic Schizophrenia _____ Simple Schizophrenia _____

Mixed _____ Late Catatonia _____

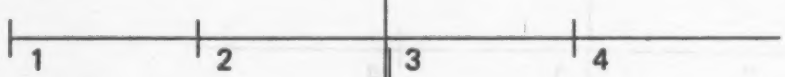
Atypical & Undifferentiated _____ Hebephrenia _____

Paranoid Schizophrenia* _____

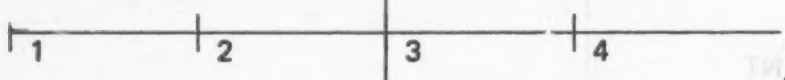
8. **AFFECT**



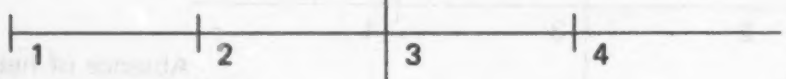
Good, preserved — Dull, blunted or apathy



Present — Absent

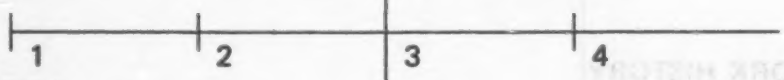


Appropriate — Inappropriate



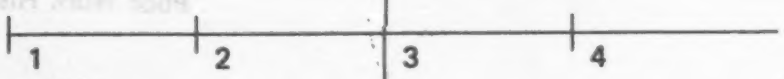
Presence of Manic Depressive Symptoms — Absence of Manic Depressive Symptoms

9. **MANNERISMS**



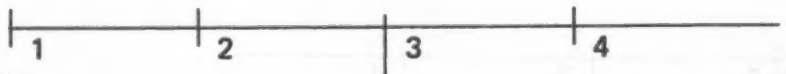
Absence of Bizarrness, Grimacing, Giggling, Stereotypy — Presence of Bizarrness, Grimacing, Giggling, Stereotypy

10. **ACTIVITY**



Presence of Motor Activity Marked Agitation & Excitement — Absence of Motor Activity Marked Agitation & Excitement

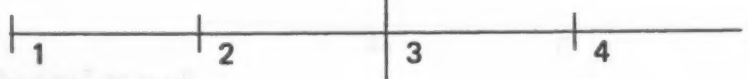
10. SENSORIUM



Presence of Confusion, Perplexity & Cloudiness

Absence of Confusion Perplexity & Cloudiness

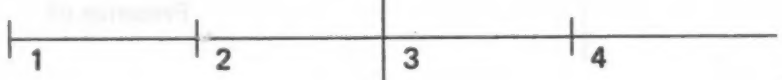
12. DELUSIONS



Absence of Ideas of Influence, Massive Persecutory, Somatic, Bizarre & Grandiose Delusions

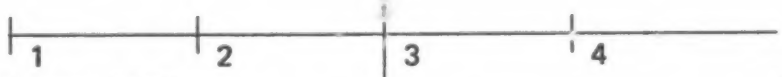
Presence of Ideas of Influence, Massive Persecutory, Somatic, Bizarre & Grandiose Delusions

13. INSIGHT AND THOUGHT PROCESSES



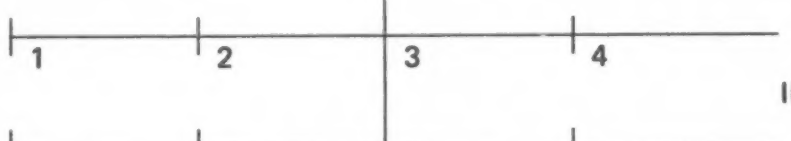
Good Insight

Poor Psychotic Insight



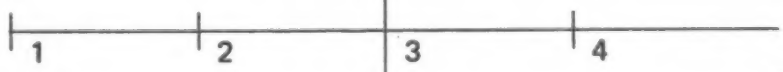
Unimpairment of Abstract Ability

Impairment of Abstract Ability



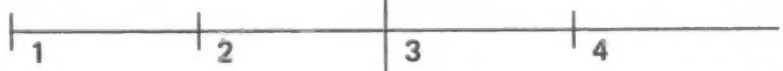
Logical Thinking

Illogical Thinking



Intact Thought Processes

Scattered Thought Processes



Absence of Autism

Presence of Autism

14. HALLUCINATIONS

Absence of Non-Specific Hallucinations

Presence of Non-Specific Hallucinations

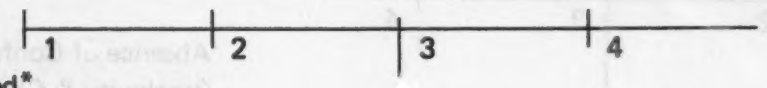
Absence of Auditory Hallucinations*

Presence of Auditory Hallucinations*

Absence of Visual Hallucinations

Presence of Visual Hallucinations*

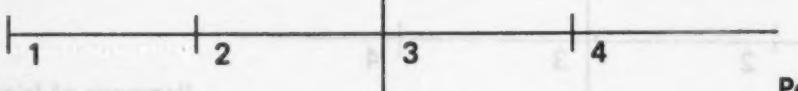
15. AGGRESSIVE BEHAVIOR



Internally Directed*

Externally Directed*

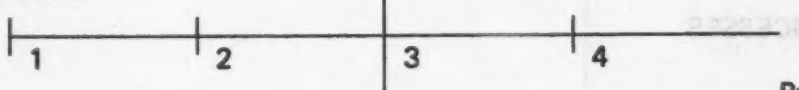
16. HOME ENVIRONMENT



Good at Time of Hospitalization

Poor at Time of Hospitalization

17. FAMILY HISTORY OF PSYCHIATRIC ILLNESS



Absence of

Presence of

*Results of Studies Indecisive.

JEWISH VOCATIONAL SERVICE-COMMUNITY WORKSHOP 229 Gratiot Avenue, Detroit, Michigan 48226

RESEARCH PROJECT RD–505

SELECTION COMMITTEE PROGNOSTIC RATING SCALE # 2 VOCATIONAL

NAME OF CLIENT: _____ RATER: _____

DATE: _____

Reasons for Selection or Rejection of Client:

Assessment of Client's Motivation for Workshop Program:

Prediction as to Whether Client will Complete JVS–CW Program:

_____ 1. Client will probably never start in the shop.
_____ 2. Client will fail during the first week.
_____ 3. Client will fail during the eight week period.
_____ 4. Client will complete the program.

Prediction as to Client's Post-Workshop Vocational Adjustment (based on one year period following completion of the workshop program):

_____ 1. Continuous employment on one or two jobs.
_____ 2. Will work most of time but on two or more jobs.
_____ 3. Will work at least half a year.
_____ 4. Only occasional and/or temporary work
_____ 5. Will work only in sheltered workshop employment.
_____ 6. Will not work at all.
_____ 7. Client will enter into training program.

JEWISH VOCATIONAL SERVICE-COMMUNITY WORKSHOP 163 Madison Avenue, Detroit, Michigan 48226

"WHAT KIND OF A PERSON AM I?"

INSTRUCTIONS: Put an "X" on the line after the answer which is closest to what you think.

NAME: _____ DATE: _____

1. Are you the kind of person who usually gets along very well with your boss; or sometimes don't you get along so well?

   a) I'm the kind who gets along very well. _____
   b) I'm the kind who gets along fairly well. _____
   c) I'm the kind who occasionally has a little trouble with my boss. _____
   d) I'm the kind who has quite a bit of trouble with my boss. _____

22. Are you the kind of person other people like to help or aren't you very much like that?

   a) I'm the kind people like to help very much. _____
   b) I'm the kind people like to help somewhat. _____
   c) I'm the kind people don't like to help very much. _____
   d) I'm the kind people don't like to help at all. _____

3. Are you the kind of person who wants help and advice from others or aren't you like that?

   a) I'm the kind who almost always wants help and advice from others. _____
   b) I'm the kind who sometimes wants help and advice from others. _____
   c) I'm the kind who rarely wants help and advice from others. _____
   d) I'm the kind who never wants help and advice from others. _____

4. Are you the kind of person who feels that you are going to be able to take care of your problems in the future or do you think you will have some trouble?

   a) I'm the kind who will take care of them very well. _____
   b) I'm the kind who will take care of them fairly well. _____
   c) I'm the kind who will probably have some trouble. _____
   d) I'm the kind who will probably have a lot of trouble. _____

5. Are you the kind of person who is full of pep and energy or do you find yourself tired without much pep and energy?

   a) I'm the kind who is almost always full of pep and energy. _____
   b) I'm the kind who is generally energetic and peppy. _____
   c) I'm the kind who is sometimes tired and lacks pep and energy. _____
   d) I'm the kind who almost always is tired and lacks pep and energy. _____

6. Are you the kind of person who usually has good luck or aren't you such a lucky person?

   a) I'm usually lucky _____
   b) I'm the kind who is fairly lucky. _____
   c) I'm the kind who generally has bad luck. _____
   d) I'm the kind who almost always has bad luck. _____

7. Are you the kind of person who is easy going and relaxed or are you tense and nervous?

   a) I'm almost always easy going and relaxed. _____
   b) I'm fairly easy going and relaxed. _____
   c) I'm somewhat tense and nervous. _____
   d) Much of the time I am tense and nervous. _____

8. Are you the kind of person who generally likes other people or don't you generally like people too much?

   a) I generally like people very much. _____
   b) I generally like people somewhat. _____
   c) I generally don't care too much about other people. _____
   d) I generally don't like other people very much at all. _____

9. Are you the kind of person whom people generally like very much or don't they like you so much?

   a) I'm the kind whom people like very much. _____
   b) I'm the kind whom people like somewhat. _____
   c) I'm the kind whom people don't like very much. _____
   d) I'm the kind whom people don't like at all. _____

10. Are you the kind of person who really likes to work or haven't you been too interested in working?

   a) I almost always like to work at a job. _____
   b) I like to work but sometimes I'm not interested. _____
   c) I'm willing to work at a job because you have to work to get along. _____
   d) If there were any other way to manage, I really wouldn't be interested in working. _____
   e) I will not have to work in order to get along. _____

11. Are you the kind of person who finds it difficult to go out and look for work or don't you mind looking for work very much?

   a) It's very hard for me to look for work. _____
   b) It's somewhat hard for me to look for work. _____
   c) It's somewhat easy for me to look for work. _____
   d) It's very easy for me to look for work. _____

12. Generally speaking are you the kind of person who thinks you're pretty healthy or not so healthy?

   a) I'm a very healthy person. _____
   b) I'm a fairly healthy person. _____
   c) I'm not such a healthy person. _____
   d) I'm a very sick person. _____

13. Are you the kind of person who thinks people at the hospital generally want you to get well and leave or don't they care much one way or the other?

   a) They very much want me to get well and leave. _____
   b) They probably want me to get well and leave. _____
   c) They don't care much one way or the other. _____
   d) They don't seem to want me to get well and leave. _____
   e) They are making it very hard for me to get well and leave. _____

14. Are you the kind of person who thinks you are about as well as most people in your home community or do you think you are sicker?

a) I think I am definitely as well as most people. _____
b) I think I'm not quite as well as most people. _____
c) I think I'm a little sicker than most people. _____
d) I think I'm considerably sicker than most people. _____

15. Are you the kind of person who thinks your stay in the hospital helped you very much or has it not been very helpful?

a) It has helped me very much. _____
b) It has helped me somewhat. _____
c) It hasn't made much difference one way or the other. _____
d) It has probably not been good for my health. _____
e) It has definitely made me worse. _____

16. Are you the kind of person who thinks your sickness will make things hard for you after you leave the hospital or don't you think your sickness will make much difference?

a) I think my sickness will make things very hard for me. _____
b) I think my sickness will make things somewhat hard for me. _____
c) I think my sickness will make things a little difficult but not too much?. _____
d) I think my sickness will not have any effect at all on me._____

17. Are you the kind of person who thinks when new people meet you for the first time after you get out of the hospital they will recognize that you have been sick or won't they recognize this?

a) People would certainly recognize that I have been sick. _____
b) People might think I was sick. _____
c) People probably would not recognize that I have been sick. _____
d) People would certainly not recognize that I have been sick. _____

18. Are you the kind of person who feels the hospital is now very much like a home to you or don't you feel this way?

a) I feel that the hospital is very much like a home to me now._____
b) I feel that the hospital is somewhat like a home to me. _____
c) I feel that the hospital is not much like a home to me. _____
d) I feel that the hospital is not at all like a home to me. _____

19. Are you the kind of person who thinks you are getting well or don't you think so?

a) I think I'm getting much better. _____
b) I think I'm getting somewhat better. _____
c) I think I'm about the same. _____
d) I think I'm somewhat worse. _____
c) I think I'm very much worse. _____

20. Are you the kind of person who thinks your illness is only a temporary thing or do you think you'll get sick again sometime in the future?

a) I definitely think it is only temporary. _____
b) I'm not so sure but I think it is only temporary. _____
c) I think it may occur again in the future. _____
d) I am sure that it will occur again in the future. _____

21. Are you the kind of person who thinks of himself as a good worker or not such a good worker?

a) I think I'm an excellent worker. _____
b) I think I'm a good worker. _____
c) I think I'm an average worker. _____
d) I think I'm a little below average as a worker. _____
e) I think I'm not a very good worker at all. _____

22. Are you the kind of person who thinks your ability to work has suffered seriously because of your illness or has your ability to work not suffered?

a) My ability to work has suffered seriously. _____
b) My ability to work has suffered considerably. _____
c) My ability to work has suffered somewhat. _____
d) My ability to work has not suffered at all. _____

23. Do you think it is a good idea to tell a prospective employer about your past sickness or don't you think this is a good idea?

a) It's a good idea to tell him right from the start. _____
b) It's a good idea to tell him but only after you're on the job awhile. _____
c) It depends on the situation. _____
d) It's probably not a good idea. _____
e) It's never a good idea. _____

24. Do you think you ought to start on a regular job as soon as you get out of the hospital or don't you think so?

a) I think I ought to start work immediately (within a month). _____
b) I think I ought to wait a short while (1 to 3 months). _____
c) I think I ought to wait for a considerable length of time (3 to 9 months). _____
d) I think I ought to wait for even a longer time (9 months to a year, or longer). _____

25. Are you the kind of person who can go right out of the hospital and get a job or do you think you need considerable job training in order to get started?

a) I believe I can get a job immediately. _____
b) I believe I need a little brush-up training or refresher in order to get a job. _____
c) I believe I need some new job training for a short time. _____
d) I believe I need a considerable amount of training in order to get a job. _____

26. Are you the kind of person who works at one company on one job for a long time or do you generally shift around frequently?

a) I generally work on one job at one company for a long time. _____
b) I generally work for one company but I change jobs at that company. _____
c) I generally work at the same kind of job but at several different companies. _____
d) I work at different jobs for different companies with fairly frequent changes. _____
e) I like to change jobs and companies as often as possible. _____

27. Are you the kind of person who thinks the home situation you'll be in when you leave the hospital will help you stay well or will likely make it difficult for you to stay well?

a) It will definitely help me to stay well. _____
b) It will probably help me to stay well. _____
c) It won't have much effect on me one way or the other. _____
d) It will probably make it somewhat difficult for me to stay well. _____
e) It will certainly make it difficult for me to stay well. _____

28. Are you the kind of person who thinks he has had enough education to get a job or do you think you have to go back to school in order to get ready for work?

a) I've had enough education to get the kind of work I want. _____
b) I probably could use a little more education but it's not really necessary to have it in order for me to get the work I want. _____
c) I will probably have to have a little more schooling (perhaps up to a year) before I can get a job. _____
d) I will probably have to have a lot more schooling (perhaps anywhere from one to four years) in order to get a job. _____

29. Are you the kind of person who thinks a hospital is a good place to stay during an illness like yours, or don't you think this?

a) It is a very good place to stay. _____
b) It's a pretty good place to stay. _____
c) It isn't too good a place to stay. _____
d) It is definitely not a good place to stay. _____

JEWISH VOCATIONAL SERVICE-COMMUNITY WORKSHOP 229 Gratiot Avenue, Detroit, Michigan 48226

RD–505

RESEARCH DATA SHEET # 2

1. Name _____ 2. Selection Date _____

3. Date of Birth _____ 4. Age at Selection _____ 5. Sex _____

6. Birthplace (specify) 1. Local _____ 2. Other U.S. _____ 3. Foreign _____

7. If Foreign born 1. Alien _____ 2. Nat. _____ 3. Yrs. in U. S. _____

8. No. of siblings (same biological mother) _____ Birth Order _____

9. Race 1. White _____ 2. Negro _____ 3. Other _____

10. Religion 1. Catholic _____ 2, Protestant _____ 3. Jewish _____
4. Other _____ 5. Not Available _____

11. Marital Status 1. Single _____ 2. Married _____ 3. Remarried _____
4. Separated _____ 5. Widowed _____ 6. Divorced _____

12. Length of Last Marriage 1. Under a year _____ 2. 1–4 yrs. _____ 3. 5 yrs. & over _____

13. No. of Children 1. None _____ 2. One _____ 3. Two _____ 4. Three _____ 5. Four & over _____

14. Educational Level:
1. No formal schooling _____ 6. Completed high school _____
2. Special or ungraded classes _____ 7. Some college (13–15) _____
3. Some Elementary school (1–7) _____ 8. Completed college (16) _____
4. Completed Elementary school _____ 9. Business, trade or special schooling _____
5. Some high school (9–11) _____ (Specify) _____

15. Work History:
1. Practically full time employment in adult working years prior to onset of illness _____
2. Employed approximately half to three-quarters of possible time _____
3. Sporadic and short-term employment _____
4. No significant work experience _____

16. Major Occupation _____ Length of time _____

2nd Occupation _____ Length of time _____

most recent Occupation _____ Length of time _____

17. Father's major occupation _____

18. Mother's major occupation _____

19. Father's place of birth (specify) 1. Local ____ 2. Other U. S. ____ 3. Foreign _____

20. Mother's place of birth (specify) 1. Local ____ 2. Other U. S. ____ 3. Foreign _____

21. Socio-economic status of parental family:

1. Well off - upper middle class and above (new car, good home, substantial savings) _____
2. Average - middle and lower middle class (car, modest home, etc.) _____
3. Below average - lower class (perhaps old car, no savings, low rent, etc.) _____
4. Poverty level - (receives charity or public welfare, no job, etc.) _____
5. Not available _____

22. Psychiatric Hospitalization of Family Members 1. Father ____ 2. Mother ____

3. Grandparents ____ 4. Siblings ____ 5. Spouse ____ 6. None _____

23. Parental family stability (excluding patient). Specify basis of rating:

1. Very unstable – considerable friction and problems, history of divorce, separation, sibling discord, etc., alcoholism, nervous breakdown, etc. _____
2. Some instability _____
3. Average adjustment _____
4. Very stable family background _____
5. Not available _____

24. Excessive family and personal residential mobility:

Yes (describe) _____ No _____

WORK HISTORY

1) Name of Employer _____ Address _____

Type of Business _____ Dates: From _____ to _____

Rate of Initial Pay _____ Final Pay _____ How Obtained _____ Why Left _____

Position and Duties: _____

_____

2) Name of Employer _____ Address _____

Type of Business _____ Dates: From _____ to _____

Rate of Initial Pay _____ Final Pay _____ How Obtained _____ Why Left _____

Position and Duties: _____

_____

3) Name of Employer _____ Address _____

Type of Business _____ Dates: From _____ to _____

Rate of Initial Pay _____ Final Pay _____ How Obtained _____ Why Left _____

Position and Duties: _____

_____

4) Name of Employer _____ Address _____

Type of Business _____ Dates: From _____ to _____

Rate of Initial Pay _____ Final Pay _____ How Obtained _____ Why Left _____

Position and Duties: _____

_____

MILITARY SERVICE: From _____ to _____ Final Rank _____ Type of Discharge _____

ADDITIONAL WORK HISTORY AND NOTES:

25. Duration of patient's symptomatology prior to initial hospitalization (specify):

Less than a year _____

For 2 years _____

More than 2 years _____

26. Patient's level of responsibility before onset of illness (specify):

1. Took considerable responsibility - e.g. maintained family affairs or acted as head of the house (male). Was solely responsible for care of home and children, if any (female). _____

_____

2. Took responsibility but was not solely responsible. _____

3. Took occasional and sporadic responsibility. _____

4. Took no responsibilities. _____

5. Information not available. _____

27. Prior to age 18 patient usually lived with:

1. Both parents _____
2. Mother only _____
3. Father only _____
4. Other relatives _____
5. Other (specify) _____
6. Not available _____

28. Immediately before present hospitalization patient usually lived with:

1. Parental family _____
2. Conjugal family _____
3. Sibling family _____
4. Child's family _____
5. Relative's family _____
6. Other household (specify) _____
7. Alone _____
8. Not available _____

29. Diagnosis at time of present admission:

1. Schizophrenic reaction, undifferentiated type _____
2. Schizophrenic reaction, paranoid type _____
3. Schizophrenia _____
4. Personality disorder- passive dependent _____
5. Personality disorder - passive - aggressive _____
6. Other (specify) _____

30. Dates and duration of previous psychiatric hospitalizations including Northville:

1. _____
2. _____
3. _____
4. _____
5. _____

31. Date of present admission – length in months to selection date:

1. Less than 3 months _____
2. 3–6 months _____
3. 6 months to 1 year _____
4. 1–2 years _____
5. 2–3 years _____
6. 3–5 years _____
7. 5–10 years _____
8. 10 years and over _____

32. Total months of all psychiatric admissions _____

33. Type of committment for this hospitalization:

1. Voluntary _____
2. Direct admission from home on a Probate Court Order _____
3. Other _____
4. Not available _____

34. Treatment in hospital (check if more than one and describe briefly):

1. Individual psychotherapy _____
2. Group psychotherapy _____
3. Electro-convulsive (EST) _____
4. Atropine _____
5. PM 10-90 _____
6. Lobotomies _____
7. Occupational Therapy _____
8. Work Therapy _____
9. Drug Therapy– (Thorazine, Stellazine, etc.) _____
10. Rehab. Services _____
11. Casework Services (including family care) _____

35. Number of LOA's since present admission _____ Rate per month _____

36. Number of LOA's during last six months _____ Rate per month _____

37. Number of visitors since present admissions _____ Rate per month _____

38. Number of visitors last six months _____ Rate per month _____

39. Describe types and number of critical incidents present hospitalization _____

_____ Rate per month _____

40. Work Therapy History: Admission Date _____ Selection Date _____

Total hours worked _____ 6 Mos. Date _____ hrs. worked _____ Pre Voc. Score _____

EVALUATION:

JEWISH VOCATIONAL SERVICE-COMMUNITY WORKSHOP 229 Gratiot Avenue, Detroit, Michigan 48226

FINAL FOLLOW UP SURVEY
RESEARCH PROJECT RD–505

NAME: _____ AGE: _____

TERMINATION DATE: _____ FOLLOW UP DATE: _____

CLASSIFICATION AT TERMINATION DATE: _____

NUMBER OF JOBS SINCE TERMINATION: _____

NAME OF COMPANY AND DATE STARTED: First Job: _____ To _____

" " " " " " Second Job: _____ To _____

" " " " " " Third Job: _____ To _____

HOW JOBS SECURED:

PRESENT WORK STATUS:

NATURE OF JOB DUTIES SINCE TERMINATION:

SALARY:

ADJUSTMENT TO WORK:

PRESENT HOSPITAL STATUS:

DATE OF DISCHARGE OR CONVALESCENT STATUS:

PRESENT TREATMENT:

CLIENT'S LIVING AND FAMILY ARRANGEMENT AT TIME OF FOLLOW UP:

PRESENT OR MOST RECENT PSYCHIATRIC EVALUATION:

DATE:

CLIENT'S FUTURE PLANS:

COMMENTS: